MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) COMMISSION MEETING

TUESDAY, SEPTEMBER 9, 2003

MDCH Public Health Building #19
North Complex Baker-Olin West
Manty Conference Rooms B & C
Lansing, Michigan

APPROVED TRANSCRIPT (MINUTES)

MEMBERS PRESENT:
Renee Turner-Bailey, Chairperson
Jack Smant, Vice Chairperson
Peter Ajluni, D.O.
Richard Breon
Bradley Corey
James K. Delaney
Edward B. Goldman
Norma Hagenow
James E. Maitland
Michael Sandler, M.D.
Michael Young. D.O.

DEPARTMENT OF ATTORNEY GENERAL STAFF PRESENT:
Ronald J. Styka

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH STAFF PRESENT:
William J. Hart, Jr.
Larry Horvath
Brenda Rogers
Jan Christensen

GENERAL PUBLIC ATTENDANCE:

There were approximately 57 people in attendance.

Commencing at or about 10:05 a.m.

MS. TURNER-BAILEY: Good morning. I'm going to call this meeting of the Certificate of Need Commission to order. It's 10:10, Tuesday, September 9th. Welcome everyone. We have a very full agenda. I apologize for the late start, but because of our full agenda and the complexity of the issues, I think there's a lot of chattering going on prior to the start of the meeting. At this time I would just like to take a moment to review the agenda. Everyone has the most recent version of the agenda. Any comments, changes? Hearing none, I'll accept a motion to approve the agenda.

MR. GOLDMAN: So moved.

MR. DELANEY: Support.

MS. TURNER-BAILEY: It's been moved and supported that we accept the agenda. All in a favor signify by saying aye. Opposed. Passed.

MS. ROGERS: Excuse me, Renee. This is Brenda Rogers, and, as a reminder today, we do have a court reporter, so if you could please identify yourselves before you speak, so could you please identify who was the maker of the motion and second, please.

MR. GOLDMAN: The motion was made by Commissioner Goldman.

MR. DELANEY: Supported by Delaney.

MS. ROGERS: Thank you.

MS. TURNER-BAILEY: Thank you. So, as a remainder, please state your name when you speak so that you can be identified by the court reporter. Declaration of Conflicts of Interest. Yes, Commissioner Sandler.

DR. SANDLER: As I said at the last meeting and probably will say at every meeting, I'm an employed physician at the Henry Ford Health System. Virtually almost every issue in this present agenda would have some effect on Henry Ford Health System and every - and I think the other two physicians probably could say the same from the hospitals that they practice. Obviously we have beds, CTs, MRIs, radiation, oncology, lithotripsy and everything else. I'm employed. I have no financial benefit regardless of the outcome of any of these issues, but I do need to state the fact that I am an employed physician at Henry Ford Health System. Although, my payment is only to interpret radiographs.

MS. TURNER-BAILEY: Thank you. Any other conflicts? So can I just clarify what you said, are you saying that you're declaring a conflict on every issue on the agenda or -

DR. SANDLER: What I'm saying is that somebody could question a conflict on every - virtually every single issue. I personally do not feel there is a conflict because of the fact that I'm an employed physician. There would be no reason to have physicians on this Commission if they - well, the reason to put physicians and hospital administrators on this - and eventually I understand a nurse and a nursing home administrator - is that they bring certain perspective, certain expertise to the Commission, but that's my understanding what the intent of the legislature was; however, by bringing them on, there are - they would be in a situation where they practice, and certainly the hospital administrators and the physicians, there are going to be institutions that have any one of these things. They all have beds. They all have CTs, MRIs, et cetera, surgical services. We all have - we do both inpatient/outpatient surgery in the Ford System, et cetera; therefore, I don't think that just because I am a physician within a health care system that there is any conflict of interest, but I do feel obligated to bring that to the attention of the Commission to keep it above ground. I don't feel there is any. I have nothing to gain regardless of the outcome of any agenda item here.

MS. TURNER-BAILEY: Are there any questions or any other declarations? Commissioner Smant.

MR. SMANT: We did receive a letter from Varnum, Riddering. I don't know if all of us in fact have it. I know that some information was gotten – which raises an issue on conflict of interest, and I don't know if you want to get into that now or later or what your pleasure is on - I'm only bringing that up as a matter that - I'm merely raising the point that we received a letter from Varnum, Riddering addressing this issue, and I don't know if this Commission wishes to address that now, later, or not at all, so I'm just bringing it to the attention that this letter's been received, and what's your pleasure?

MS. TURNER-BAILEY: Well, since we have had that inquiry, I'd like to - I have gotten some opinion from Ron, if you wouldn't mind speaking to this issue at this point in the agenda, I don't think it's the kind of agenda item that normally requires action, but since we have had these inquiries, I'd appreciate it if you could speak to that, and we can, as a Commission, speak through how we might want to address this issue.

MR. STYKA: Well, first you have a choice, and you can deal with this now or you can deal with this as the item that may be affected comes up. The other thing is that your Bylaws make it - can spell out a very clear procedure that you should follow, and I think you are familiar with that procedure in the Bylaws, and the - when a conflict - potential conflict is brought to your attention, the commissioners then can question the member who might have a conflict until they feel satisfied as to whether or not - how they feel about that potential conflict, and then have a vote as to whether or not the person should be allowed to participate in the vote on a particular item. It's very clear from the Bylaws that they're not excluded from discussions, and they certainly can participate up to the time of the vote no matter what you decide; so at this point, I guess, if you want to discuss it now, you can, by having a dialog with Dr. Sandler, otherwise, you can just put it off until the end of the agenda items.

MS. TURNER-BAILEY: Commissioner Hagenow.

MS. HAGENOW: I was also named as being part of Ascension Health, and, therefore, having an undo amount of conflict, I guess, I personally do not agree with that. I think that there's just about - as Dr. Sandler has said, there's every issue on here as a CEO of Ascension Health System that I would find positive or negative in some way, and that when I became a commissioner, I asked that question at the legislative hearing whether indeed I have a conflict of everything because of my role; and what I was told was that you bring your expertise; if is direct in terms of if I was voting on bed transfers for Genesys or a direct conflict of decisions, then I should abstain, but otherwise I was called to the higher good of my knowledge and not for my personal interest; and I think it's a stretch to say that I have a direct conflict on any of these issues except in the same sense that Dr. Sandler projected it, that there's a vested interest in all of these in the business sort of a way but not today that I have some conflict on one particular issue.

MR. STYKA: Madam Chair.

MS. TURNER-BAILEY: Mr. Styka:

MR. STYKA: The way I would do this now is, two people have risen ahead or have brought up perhaps that there could be an appearance of a conflict, and at this point you decide whether or not you want to deal with it now or later until the issues arise.

MS. TURNER-BAILEY: Well, I think, first of all, I'd like to probably wait until the issues arise and - because I don't know that you can make any sort of blanket decision in a forum like this because there are items - item-by-item situations that would have to be dealt with. I'm wondering, however, if there might be because of the new make-up of the commission and the fact that, as Commissioners Sandler and Hagenow pointed out, there are going to be issues that are going to arise continuously where these questions might come up. And I'm wondering if there's anyway that we can move forward in sort of getting a - if not a formal opinion, but some sort of an interpretation that the Commission can go by in making a decision on an item-by-item basis. Do you have an opinion on that?

MR. STYKA: Well, I certainly can give you my opinion, but, actually, ultimately the conflict questions are item-by-item questions. Clearly the legislature intended that there be expertise on this Commission of various kinds including physicians and people who represent various aspects of the health care industry, and certainly in general just a remote connection or the fact that they - someone works in the industry, you know, is not a conflict, and that's always been at one point or another a question before this Commission, prior to the current membership, even though there wasn't a requirement that you did have physicians on the Commission and they once or twice did recluse themselves because perhaps their hospital they practiced in was an applicant in an area that was under consideration, but, otherwise, they did not, and the Commission never felt - although it was always discussed - never felt it necessary to require them to recluse themselves. So, obviously, you have to look at it on at a case-per-case basis because in the broadest sense, as it's been pointed out by the two commissioners that spoke, theoretically everyone has some sort of conflict of interest, so, you know, I would say that there has to be some sort of direct connection. There has to be - there have been prior opinions that have been given to this Commission, one by Assistant Attorney General Taube who preceded me back in '96 dealing with Dr. Krause, who was a U of M physician; and MRI Services, for example, came up in front of the Commission. U of M was someone who actually - it was one of the two or three hospitals that was actually able to benefit from that proposed standard because it involved a combination research/clinical MRI, and Dr. Krause raised the fact that he might be in conflict, and advice was sought from the Attorney General, and at that time Mr. Taube indicated the process that I mentioned earlier that this Commission would have to look at it on an individual case basis, and by questioning him, make a decision as to whether or not to allow him to proceed since he did not feel that it was - he had the kind of interest that would be a conflict; and in the end, the Commission did allow Dr. Krause to participate because perhaps - and I wasn't there. It was Mr. Taube, by predecessor, but perhaps it was like Dr. Sandler said, you know, he was paid for other things and not MRIs. We also had a request in 2001 from this Commission concerning ad hoc committees, which are no longer in the statute, but the ad hoc committees under the Bylaws were governed by exactly the same provisions of the Bylaws on conflicts that this Commission is; and in that one I wrote some advice to you, to Mr. Maitland, the Chairman at the time, and talked about the connections - and the direct connections that are needed in order to have a conflict, and that, you know, might be helpful for everyone to look at. I did cite to some ethic board

opinions in there; and, in summary, I said: At least the following may be found - at least the following, which means there could be others - may be found under the Bylaws to be a conflict of interest: Individuals with an ownership interest that affect a health facility or modality, individuals who exercise a degree of control (such as members of the governing board) that would affect a health facility or modality, individuals whose compensation is determined by a formula related to the outcome of an ad hoc's committee deliberations; in this case it would be the Commission and its agents; and individuals, who because of the method of their compensation, can influence the amount of that compensation through the content of the review standard under review. Those are things I found at a minimum that would certainly signal a conflict of interest back in 2001 when I looked at the question. Finally, the philosophical preferences of organizations and their representatives are not at issue here. The required makeup of the Commission mandated by the law - I'm reading that in place of the ad hoc committees - contemplates advocates of the diverse views sitting on these committees or this Commission. They are of necessity a mix of providers, payers, purchasers, consumer advocates, and now we have physicians, representatives of hospitals, et cetera, and conflicts of interest sufficient to trigger the procedures of the Bylaws must involve the direct interests of the type expressed above. I would still stand by that advice with regard to the issue that's here today. Now, if you are concerned enough that you want something else, there - I believe there's a procedure by which you could seek an opinion from the State Ethics Board, but that would be a little bit of time in the making. I could certainly assist you posing the question to the State Ethics Board.

MS. TURNER-BAILEY: Thank you very much for that advice. I think in hearing your suggestion that we might be able to get an opinion from the Ethics Board sounds very comforting to me, if that's something we could move forward in doing. I don't know if the Commission would agree that that's a step that you'd like to take. I'm hoping that it would alleviate these kinds of discussions or at least shorten these kinds of discussions in the future as we come up with various items. Are there any comments with regards to that particular issue? Commissioner Smant.

MR. SMANT: Well, I agree - I agree with the comments made by both commissioners that there's hardly an issue that probably they could not be faced with being charged with a conflict, so it has nothing to do with the commissioners or any personal issue. This Commission has changed and has changed in the effect of having persons representing specific areas of medical expertise, et cetera, on the Board, a little bit more than we had in the past, so I think I would favor us having a clarification just because I don't think we want to have this discussion every month. If you were looking for a motion, I would so move that we ask for clarification from the Ethics Board.

MR. AJLUNI: Second.

MS. TURNER-BAILEY: Okay. Commissioner Smant.

MR. SMANT: Smant.

MS. TURNER-BAILEY: He said that in the beginning. And it was supported by Dr. Ajluni, Commissioner Ajluni. Would be will, as some clarification for you motion to allow your chair to work with Mr. Smant to - put that. Okay. All right. So it's been moved and seconded that we seek an opinion from the Ethics Board - clarification from the Ethics Board with regards to dealing with conflicts of interest. Is there any discussion? Yes, Commissioner Hagenow.

MS. HAGENOW: I'm concerned about - is it on? I'm concerned that today there is a political reason why somebody would want me and Dr. Sandler not to vote, and the next meeting there is a political reason why Rick Breon shouldn't vote or somebody else shouldn't vote, and that the clarification has to be more clear about what directives because otherwise I think we're up for political antagonism to be the primary reason that it is put to us as a conflict of interest, and I certainly want to be above board, but I also don't want to be a victim of just one political side or the other but rather be able to exercise my judgment as a commissioner for the higher good, which I believe I can come down on reasons why it might be good for me or not good for me on every one of these issues, but I'm called to this role for a higher good, and so the direct part comes to me, the clarification part.

MS. TURNER-BAILEY: Commission Sandler.

DR. SANDLER: Yeah. I actually want to second and echo what Commissioner Hagenow has said and point out the following to my fellow commissioners. Hired guns will want to pick some commissioners off because their side perceives them as not being likely to vote. I can go back to this - to several issues on the agenda and point out Dr. Ajluni, my good friend, is on the Board of Trustees of a hospital involved in a lawsuit, a plaintiff in a lawsuit that we all know about. I can say that Renee Turner-Bailey's employer is probably - the Economic Alliance, is also in a lawsuit; however, that does not mean they cannot act with integrity on this and all other issues. And I'm a little concerned about losing civility among us to act in the public good if we give in to what amounts to hired guns trying to pressure us.

MS. TURNER-BAILEY: And I think, - certainly I for one am not questioning anyone's integrity, let me just start off by saying that, but hoping that if we can get an - if we can an opinion that is clear, that - so it gets us past those types of issues, that it allows the commission to use that kind of interpretation to make decisions which are - which are without rank or - if you will. That's the reason why I'm going to vote yes on this motion. Any further discussion?

MR. DELANEY: Ron, what sense do you have as to the time line for a process like this?

MR. STYKA: Well, I haven't actually been involved with a State Ethics Board opinion before. I have a concern that struck me as I was looking back at the advice I've given you before that I believe ethic opinions have to deal with a specific circumstance, which means you may not be able to get what you're really seeking, which is a broad and general statement, which would mean you'd have to put before the Ethics Board the specific circumstances of, you know, the item on the agenda that's been raised concerning Dr. Sandler and Commissioner - help me out.

MS. HAGENOW: Hagenow.

MR. STYKA: Hagenow. Thank you. I knew it was an H. And I'm not sure that that's going to answer your question, you know, in the broader since ongoingly. If you look at page three of the opinion that I gave to Mr. Maitland that I handed out to you a little while ago, I did talk about the term "direct" at the bottom of that page, and you'll notice - I don't think the Ethics Board has ever ruled specifically this is what direct means; that they can take individual cases and they talk about whether or not they see an ethics violation, but there I talk about direct meaning proceeding or lying in a straight course or line; not deviating or swerving without intervening persons, conditions, or agencies; immediate of unbroken descent or lineal. I mention that in this regard the Ethics Board several rulings made it clear that an interest becomes direct where a decision has a straight-line immediate effect on the interested entity or person. And then I say, "Thus, a physician who works for a hospital that already employs or may wish to apply in the future to employ a health care service that is the subject of review is not in a direct personal, professional or monetary conflict of interest. Not that dissimilar from what was mentioned earlier in the meeting. However, the same physician employed by a pending applicant for a health care service under review is in a direct conflict of interest. And then I gave you the summary I read to you earlier. We can certainly try to get something from the Ethics Board. I'm not - having not been prepared ahead of time for that question, I don't know exactly what procedure it is, so I can't really answer the commissioner's question as to the time line, but we certainly could try; and, obviously, it's not going to be something you're going to find out in a few weeks. Historically these kinds of groups can take many months to make their decisions. They have many items on their agendas. And these are things that take time. I don't think you'll get a question and answer very quickly, though.

MR. DELANEY: Mr. Delaney again. I guess my concern is the legislature reconstituted the Commission for a reason and wanted the expertise of those in the medical profession, and we're either going to - they're either going to be included on the Commission or they're not going to be included on the Commission, and I certainly don't feel that's these folks with this expertise should be kept from voting on all issues that may touch their organization. In a sense, most of these issues touch all of us anyway, even in the private sector, so my opinion is it's probably, frankly, a waste of time.

MS. TURNER-BAILEY: Commissioner Breon.

MR. BREON: Yes. You know, I serve on lots of boards and have had a lot of interaction with board members. There are always going to be issues come up with conflict of interest. You can't write a blanket statement that encompasses everybody; or, as stated before, I think I'd probably have to pass on about 80 percent of these

things. I think we have to take them on an issue-by-issue basis, and I think we'll know it when we see it, and I think trying to debate about having an encompassing statement that covers everything, I just don't think is going to happen. I think that I certainly wouldn't have any problem with having everyone vote on all these issues. I think there may be conflicts of interests that will come up and we'll have to address them individually but I think we can move the process on.

MR. STYKA: Again, it's not my role to give you a ruling here on whether or not either of these commissioners is in conflict. Your Bylaws clearly provide that you are to decide that by a vote of your membership.

MS. TURNER-BAILEY: Okay. Well, there's a motion on the table at this point with regards to seeking an opinion from the Ethics Board with regard to a clarification of the issue of conflict of interest, and hopefully a more detailed definition of what direct means. I'm paraphrasing your motion, Commissioner Smant. And it has been supported. There has been discussion. I've heard some various opinions on this matter, but - and I actually do have a card on this issue which I'm sort of reluctant to throw into this particular discussion, but I may take this after we take our vote. Are we prepared for a vote?

MR. BREON: Yes.

MS. TURNER-BAILEY: Okay. All those in favor signify by saying aye. Opposed? Okay. We have two opposed, which means the motion carries, and we will seek that opinion - I don't - I guess I need to come back and speak to you, Ron, and say, does that mean - does that affect everything we do today or can we move forward with regards to the items - individual items that are going on today, because, of course, you know, today is today, and today is not months from now so.

MR. STYKA: Well -

MS. TURNER-BAILEY: I think I'm hearing we should move forward.

MR. STYKA: I guess your motion - and it would be nice if it could be read back. I mean, it's to seek an opinion on the issue of what is a direct conflict of interest; correct?

MS. TURNER-BAILEY: Yes.

MR. STYKA: I don't think that has been decided for any item on today's agenda -

MS. TURNER-BAILEY: Okay.

MR. STYKA: - and you should still go forward and then, you know, decide the issues as they come up.

MS. TURNER-BAILEY: Great. Pete.

MR. AJLUNI: I'm just going to echo his comments. I think we should proceed. I think in lieu of any report from the Ethics Committee, we have Bylaws that he alluded to before which I think state, if I understood you correctly, they should be decided on a case-by-case basis.

MR. STYKA: That's correct.

MR. AJLUNI: And I welcome their input and I think we should have it.

MS. TURNER-BAILEY: Okay. Thank you.

MR. STYKA: And I apologize. It was just pointed out to me that they photocopied every third page of my opinions I handed you, so we'll try to get that fixed before -

MS. TURNER-BAILEY: But we did have page three, though.

MR. STYKA: You had the important page.

MS. TURNER-BAILEY: Okay. I have one card that says conflict of interest, and I'm going to take that since we're still on that. Let me make sure there's only one. We're still on that point on the agenda. Stephen Afendoulis.

MR. AFENDOULIS: May it please the Commission. My name is Steve Afendoulis. I am currently the chairman of the trial department at the Varnum Law Firm and the author of the letter that has been previously referenced. I also am currently serving as lead trial counsel in connection with litigation that is pending challenging the constitutionality of certain sections of Public Act 619; but the purpose of my public comment today deals with the conflict of interest issue, and I am passing out the written comments that I'd ask the commissioners to consider -

MR. NASH: They have them.

MR. AFENDOULIS: - and won't reiterate but would like to emphasize a couple of very important things that I think the Commission needs to consider as it goes forward and addresses specific issues. The first of which is that your own Bylaws incorporate the State Code of Ethics, and there is no question as public servants that all of you as commissioners are bound by the State Code of Ethics, and the standard for conflicts of interests are broader and different than a direct personal financial interest. In fact, the statutory ethics provision states that any employment that may tend to affect the impartiality represents a conflict of interest. Now, you've raised an interesting and important point, and that is that the whole intent of Public Act 619 was to provide expertise on this Commission. There isn't any question about that, and all of you as commissioners or many of you represent certain constituents, so how is it that you determine at what point in time a conflict is sufficient enough that requires a reclusal of a particular vote? Certainly if you're a hospital representative, any issue that may affect a hospital is not the kind of issue that would require a reclusal for a conflict of interest. But in the case of a couple of commissioners in connection with the bed standards, we have a situation where we have commissioners who have been - in the case of Commissioner Sandler - and, again, this is not an issue about his integrity. It's an issue about the statutory interpretation - that has been publicly thanked for his role in the manner in which he has voted on the bed standards because that is helping his employer, thanked by his employer in an internal communication for voting the way he did in connection with a CON Commission vote, in helping his employer achieve the strategic objective of establishing a hospital in West Bloomfield. Now, let's take a look at that and read the statutory language. Is that employment that may tend to impair judgment? I have no doubt that Commissioners Sandler and Hagenow believe in their heart of hearts that they can act in an impartial way, and that may be the case, but that's not the legal test because there's more at issue in the manner in which you make your decisions. There's more at issue than that particular vote. What's at stake is the integrity of your process. That is the reason for our rules of ethics. It is so whether you win or lose on an issue that all of these people in the public when they leave say that the decision was made in an impartial and fair manner, and where you have a vote that might be decided by employees of the very entities that very specifically benefit as a consequence of your vote, then that represents a violation of the state rules of ethics not because they acted in a way that was bias but because it infringes on the fairness and manner in which your decisions will be accepted as commissioners by the public. That is the standard. So I suggest to you as you address this issue perceptively that the question that you ought to put in very specific way because I agree with Commissioner Breon, you can't deal with conflicts in a vacuum, you must deal with them on a case-by-case basis, so the question we would pose to the State Ethics Commission is where we have a commissioner who is employed by Henry Ford Health Care Systems, where we have a standard that will very specifically allow Henry Ford Health Care Systems to achieve its long-term and strategic objective of having a hospital in West Bloomfield and where that employer has publicly thanked that commissioner for the manner in which he's voted to help Henry Ford and accomplish that strategic objective, does that amount to employment that, quote, may tend to impair the vote, and, therefore, color the decision of this Commission? And I suggest to you that if you put that question - which is the only question on the table for Commissioners Hagenow and Dr. Sandler, if you put that question to the State Ethics Commission, there is no question what the answer is going to be, and it isn't whether they're going to act in a bias fashion in this case, it is to protect the integrity of the process, and that's why we have these rules. So I would be welcome to any questions any of the commissioners may have.

MS. TURNER-BAILEY: Commissioner Goldman.

MR. GOLDMAN: Let me see if I understand the question that you're asking us to pose. You, in your question, stated that it was in part limited to people who have been publicly thanked, and then you talked about Commissioner Hagenow, but you have not presented any evidence about her being publicly thanked. Was that your intent?

MR. AFENDOULIS: No. And that's a good question. I think where you are employed by the health care provider that stands very specifically and very directly to benefit as a consequence of a proposed rule, different from - and I emphasize this - different from hospitals in general, because representing hospitals in general is, you know, your job as the representative of hospitals; but where you have a situation or proposed regulation or a rule or a standard that specifically is directed to convey a privilege or a benefit to a particular or two particular hospitals, and you happen to be a commissioner voting on that standard, at that point in time we are no longer talking about the intent of the changes in Public Act 619, which is to represent hospitals in general or constituents in general or the nurses or whatever constituency you happen to represent.

MR. GOLDMAN: So that if there was a proposal that came before this Commission that would allow any academic health center to expend a particular service, since I work for an academic health center, I would then have an interest that was a direct interest, and under your approach you believe the State Board of Ethics would say that I should recluse myself, not from discussion, but from vote on that issue?

MR. AFENDOULIS: If it is simply the category generally, I would suggest to you that you are fulfilling your function as a commissioner in representing your constituency, but where you have proposed standards that very specifically single out and delineate and are intended to convey a direct benefit on a particular hospital or two particular hospitals, under those circumstances I believe that the conflict of interest is direct and it requires a reclusal from the vote.

MR. GOLDMAN: So your point really is not whether somebody was publicly thanked or not, your point is if there is a proposal before this Board that would benefit one or more particular hospitals in this state, particular hospitals in the Detroit area, and there are people directly employed by those hospitals whose hospitals would specifically stand to benefit, that's the question that you think we should pose to the State Board of Ethics?

MR. AFENDOULIS: That's exactly the question, and I believe that that's the intent of Public Act 619, is that you are to represent your constituencies generally.

MR. GOLDMAN: What about the flip side of that question; what if there were hypothetically people on this Board whose hospitals may receive direct competition from hospitals in Detroit; that would mean to the suburbs, would they be, under your approach, precluded from voting on this issue?

MR. AFENDOULIS: Absolutely. I think that if you've got a situation where you have a representative - and this isn't a rule for - this is something the Commission's going to have to deal with now prospectively, and if we were in a situation where one of the CON commissioners happened to be the CEO of a plaintiff hospital that was challenging the constitutionality of 619, under those circumstances I would hope that that individual would, for the benefit of the process, for the integrity of the process, say I have employment that may - and that's the test - that may tend to influence my judgment, and under those circumstances I'm going to - I can participate in the discussion, I can give my opinions; but under those circumstances, I'm going to recluse myself from that particular vote.

MR. GOLDMAN: Or the actual conflict or appearance thereof?

MR. AFENDOULIS: That's exactly the standard; and if you stop and think, the Rules of Ethics apply across the board well beyond this Commission, and that is the exact - I draw the analogy of a judge that has the appearance of bias. The judge may in his heart of hearts believe that he can act in an impartial way, but if there is that appearance of bias, in order to protect the integrity of the decision-making process and the acceptance of our judicial decisions, it requires judges to recluse themselves even in that situation where they can honestly in their heart of hearts believe they can act in an impartial fashion.

MR. GOLDMAN: So I think the sense of your comments to us would help us to draft the questions to the State Board of Ethics. It's an interesting question in the sense that the intent of the Public Act was to put people in the industry, if you will, on a commission that to some extent regulates the industry.

MR. AFENDOULIS: No question, and we don't want to lose the intent of the Act by simply saying this is a issue that affects nurses, and, therefore, whoever the CON commissioner is that represents that constituency is

reclused from voting. That would be contrary to the intent of the Act, but here, especially in connection with the hospital bed standards, that's not the situation that we have.

MS. TURNER-BAILEY: Okay. Any other questions? Commissioner Hagenow.

MS. HAGENOW: I guess I'm intrigued by how my parent company is what you are calling as a direct relationship because I see Ascension Health in the state as having multiple constituents, and I could be - I have to walk - walk through the consideration of this bed transfer issue from the public good because what might be good for St. John's may not necessarily be good for Genesys or may not be good for Tawas or other parts of the Ascension Health, so for me to be drawn to that as the reason why I have a conflict of interest, it seems to me it should be more directly related to Genesys because I have that higher good that I'm going to have to go to even within your our system.

MR. AFENDOULIS: Sure. Commissioner Hagenow, I'll be the first to admit that the issue regarding a conflict of interest for you I think is at least arguable and not as clear as the situation involving Commission Sandler. But the other side of that is appreciate the fundamental purpose of our Code of Ethics, and that is, when we all leave and we have to deal with the public, can we support our decision as being fair and impartial, and if we have a vote on hospital bed standards that is decided by, for example, two votes, and your vote and Dr. Sandler's vote happened to be the swing votes, then what is the public comment following that going to be. That vote passed because we had a Henry Ford vote and a Providence St. John Ascension vote that swung it. And, as you much as you talk about politics, I'm not here as a hired gun. This isn't a political issue. It is an issue of ethics, and it is the public perception of the commission that is important. That's what's important to maintain the integrity of the work that you all do; that it was a fair process regardless of what standards are passed if they were done in a fair and impartial way, and they weren't influenced by that kind of relationship.

MS. HAGENOW: I would come as a contrary opinion that two people not allowed to vote on the issue could be non-fair process as well.

MR. AFENDOULIS: Not if the people who are not allowed to vote have a - by voting would commit an ethical violation under our statute.

MS. HAGENOW: Well, that's why the ethical consideration of what's direct or not, and I agree with the need for maybe further clarification on that, but I'm saying that a fair process should not be influenced either way by politics.

MR. AFENDOULIS: On that we agree, and that's how come my situation is that you do, in fact, defer the issue, and that you send - when you send that issue - which is why we have a State Ethics Board, that is their function. When you send that issue, that you don't send a general issue, but what you do is you put it in context so that there is a manner in which the State Ethics Board can understand and appreciate and work through where that line is going to be drawn that will both accomplish the purposes of Public Act 619, but also protect to make sure that the decisions that are made by the Certificate of Need Commission (CON) are viewed by the public as fair and impartial.

MS. TURNER-BAILEY: Commission Sandler.

DR. SANDLER: Yeah, I certainly am not planning on debating you, and what I'm going to say, I don't think even requires a comeback from you, but, of course, it's a free country. First, you keep saying that I - that the commissioners have a constituency group, have an interest group, and I would take exception to that. I represent no specific interest group in terms of people to whom I have to answer to. Yes, I'm the M.D. here and I happen to also be on the Chair of the Board of the State Medical Society, which some of you know. When I interviewed for this, I made it very clear even at the interview process, I will bring the perspective of a practicing physician, and specifically the expertise of a practicing radiologist, since there are - four of the covered standards are radiology standards, but I do not represent the views of MSMS. I don't agree with some of their views on CON and they're well aware of it, as a matter of fact, that I don't agree with it. So I represent - I've been very clear I represent the ten million people in this state and not a specific interest group when I made my decisions. So that's the first exception I wish to take on what you're saying. Second of all, in terms of public thanking. Technically you are correct, some throwaway piece of paper that's distributed to employees that frankly I had never seen until I saw it in your E-mail was done. It probably shouldn't have been, but I've never

seen it, and it certainly didn't affect my vote and would never affect my vote today. Three, you did - I don't have your E-mail right in front of me, but you said in your E-mail something about I shouldn't have voted last time. Well, specifically I believe it was Commissioner Ajluni - I'm not certain who it was - asked the Assistant Attorney General whether or not I should be able to vote, and he said yes.

MR. AFENDOULIS: Ron and I have been known to disagree in the past, by the way.

DR. SANDLER: And the genesis of me voting was the formal opinion of our lawyer. I did not suddenly decide to vote contrary to what everybody else thought, I'm going to vote, I don't care what anyone says. I deferred to our lawyer. And no one's questioning your integrity, but you are making a living doing this; and you say you're not a hired gun, you're not doing this for free, I assume, you have a client who's paying you.

MR. AFENDOULIS: You're incorrect today. In fact, I advised the hospital that today I am not on the clock and I am here as a citizen to raise this issue.

DR. SANDLER: I'm not questioning your integrity but the credibility is not there.

MS. TURNER-BAILEY: Thank you very much.

MR. AFENDOULIS: Thank you very much, all of you, for your time.

MS. TURNER-BAILEY: Mike Baker. A brief comment, if you don't mind. Thank you. We're not taking action on this particular item.

MR. STYKA: I need to clarify something. At the June 10th meeting, I was asked whether or not Dr. Sandler could vote on the question of whether or not you had any power whatsoever to make any decision under (9), and I hope I said he could vote on that issue. I wasn't asked later on concerning the actual standards of (inaudible).

DR. SANDLER: Yeah. I apologize. That's exactly what I meant. That specific vote you were asked and you said yes.

MR. STYKA: So I'm not sure that in this one instance Mr. Afendoulis and I would actually disagree.

MS. TURNER-BAILEY: Yes.

MR. BAKER: My name is Michael Baker and I am a hired gun.

MS. TURNER-BAILEY: Thank you for stating that.

MR. BAKER: And I am one of the counsel on your side or on the department's side in the litigation that Mr. Afendoulis has brought, and I don't want to drag this out at all, but, number one, for what you're being asked to do today is vote to carry out the language in 619, and this is not acting on an application that this is a public policy issue that you're going to be asked to undertake today, and it's for you to decide today whether any particular member has conflict. And if we take Mr. Afendoulis' statements at face value, he could say exactly the same thing to anyone who's employed in any industry, maybe involved with groups that have different opinions on this. And if Ms. Hagenow and Dr. Sandler convince you that they don't have a direct interest in the outcome of this and that their vote is based on all kinds of different factors that is not controlled by their employer or the parent company of their employer, that's for you to decide. And what we're asking for you to do today is take the vote when the time comes, and it seems pretty clear that Ms. Hagenow does not have any direct conflict, and to us it seems equally clear that if you question Dr. Sandler, he will convince you that he doesn't have any conflict in this case. Thank you.

MS. TURNER-BAILEY: Thank you. Any questions?

MR. MAITLAND: I'm a little confused -

MS. TURNER-BAILEY: Mr. Maitland.

MR. MAITLAND: - who you said you represent. You said you're representing me?

MR. BAKER: No. No. I'm one of the lawyers on the same side as the department in the litigation or...

MR. MAITLAND: The State of Michigan's -

MR. BAKER: I work at St. John.

MR. MAITLAND: - paying you?

MR. BAKER: No. I work for St. John Health System.

MR. MAITLAND: Oh, okay.

MR. BAKER: Yes.

MR. MAITLAND: It was hard getting that out of you.

MR. BAKER: I'm sorry. I just guessed you remembered that from last time.

MR. MAITLAND: No, I don't remember anything from last time.

MR. BAKER: Don't make any doubt about it; I represent St. John Health System.

MR. MAITLAND: You don't represent me.

MR. BAKER: I do not represent you but we're on the same side on the litigation as the commonwealth - as the State of Michigan.

MR. MAITLAND: Okay.

MR. BAKER: Thank you.

MR. MAITLAND: You know, I don't think we're ever going to get anywhere if we -

MS. TURNER-BAILEY: If we don't move on.

MR. MAITLAND: - don't proceed.

MS. TURNER-BAILEY: Right. I agree.

MR. MAITLAND: But I do believe Mr. Styka's statement that we need a specific reason to go to the code - the Ethics Board, but I don't know if we can do it retroactively, but I guess if you need a specific thing from the past, we could perhaps discuss Dr. Sandler's motion not to vote at the last meeting.

MR. STYKA: Well, you could do something (inaudible - you can ask for an advisory.

MR. MAITLAND: Oh, you can? But you said you needed a specific reason -

MR. STYKA: I've been reading the ethics act.

MR. MAITLAND: Oh, you changed your mind then.

MR. STYKA: I told you I didn't know and I've been reading the ethics act while the other people have been talking.

MR. MAITLAND: Then you don't need a specific -

MR. STYKA: You can ask for an advisory opinion -

MR. MAITLAND: Then the motion was to send this to the -

MR. STYKA: - but the advisory opinion will be specific; I mean, it has to relate to some sort of facts, it just can't be what does direct mean because you'll never get an answer.

DR. SANDLER: This is simply another example of the staff always being on the ball, always thinking,

Mr. Maitland, Commissioner Maitland.

MR. STYKA: One final comment on this before you move on in your agenda. I notice there's an Attorney General opinion from 1980 dealing with ethics, and here's the scenario, so you might want to think about this factual scenario. You have a public entity and a member of that public entity is also a one-percent stockholder in a corporation and is employed by that corporation but was not directly involved in the development of a contract between the corporation and the public entity that he was part of and did not represent either party of the negotiations or approve the contract at the corporation side, and this was held not to be a violation by the Ethics Commission.

MS. TURNER-BAILEY: Thank you. Now we'll move on to action items on the agenda.

MR. GOLDMAN: Can I just make one quick comment?

MS. TURNER-BAILEY: Sure. Commissioner Goldman, and I know this is not on this issue.

MR. GOLDMAN: This is not on this issue at all. I just wanted to let people in the audience who were friends of Steve Harrington know about the memorial plans for him. As you know, he was a senior health planner at the university. He died in July of this year, and we are going to have a memorial service to celebrate his life Friday, September 12, from 1:30 to 3:30 in Dow Auditorium, Townsley Center, on the University of Michigan Health System Campus, so that's Friday, September 12, 1:30 to 3:30, this Friday, on the - in the Townsley Lobby, Dow Auditorium on the campus. If you need instructions or how to get there, you can certainly call my office or you can call just information desk at the hospital and they'll be glad to give you instructions. It's this Friday from 1:30 to 3:30. Thank you very much.

MS. TURNER-BAILEY: Thank you, Commissioner Goldman. With regards to the minutes of the June 10th meeting, I would like the commissioners to tell me if there are any corrections, comments - corrections to those minutes.

MR. MAITLAND: I read the transcript and every word was exactly right and I move to approve as presented.

MR. DELANEY: Supported.

DR. SANDLER: I don't mean to debate Mr. Maitland, but he just said he couldn't remember anything from the last meeting.

MR. MAITLAND: I was being facetious.

DR. SANDLER: Oh.

MS. TURNER-BAILEY: Commissioner Maitland has moved, it's been supported by Commissioner Delaney that we accept the minutes from the June 10th meeting as the minutes. All those in favor signify by saying aye. Opposed? Thank you. Hospital Bed Standards Follow Up from June 10th, 2003 Action. Brenda, are you going to walk through those?

MR. MAITLAND: Excuse me.

MS. TURNER-BAILEY: Okay. I'm sorry.

MR. MAITLAND: Mr. Maitland has a technical question before we get into the voting process today. Do our Bylaws say that a positive vote would always be six members or is it a majority of those present in voting?

MR. STYKA: The statute says you have to have at least six positive votes.

MR. MAITLAND: So it's -

MS. TURNER-BAILEY: For every - for any issue?

MR. STYKA: For any issue.

MS. TURNER-BAILEY: Okay.

MR. MAITLAND: So it's a majority of the Commission even if they're not -

MR. STYKA: A full eleven commission.

MR. MAITLAND: Thank you.

MS. TURNER-BAILEY: Brenda. I'm sorry. Jan, are you going to speak to this?

MR. CHRISTENSEN: Yes.

MS. TURNER-BAILEY: Thank you.

MR. CHRISTENSEN: I'm Jan Christensen, Health Policy Director for Michigan Department of Community Health. What you have in front of you is a copy of the original standards that were voted on by the Commission in June to go out for public hearing. Since that public hearing, we had - we did have the public hearing and received comments on it. We received additional comments from a variety of sources over the period of time from the public hearing until these revisions were put in place. The standards for the commissioners are highlighted. The blue language is the language that was in the standard that was approved by the commissioner to go out; and as several commissioners have noted since then, there was some suggestions and amendments. The Chair of the Commission did send a copy of the proposed standards that were sent out to the Joint Legislative Oversight Committee for the CON Commission, and they've made some comments and provided some input back in response to the letter. And the Chairman's - the Chairperson's letter, there was an indication that there was some tweeking and adjustments to the standard that would need to be done before the Commission would see them again. The highlighting in red underlined all caps in the document that you have is the revisions to the standards. The revisions largely do two things; they help conform the draft proposed standard to the actual wording of PA 619, and they impose limitations beyond the limitations that were in 619, significant limitations. The major areas begin - and I think we have the color copies for the commissioners in front of you, but we did attempt to E-mail the standard job, and I understood from several commissioners that not all E-mails were received, but we put the standard up on the Web earlier last week, and largely the additions to this standard reflect restrictions on what was the previous standard. We did have a number of meetings with various individuals and groups involved in the standard and had received a great deal of comments and we tried to incorporate that. If you go to page 2 of 32, it's the second page, the first red underline text identifies that there is a section in 619 that requires the Commission within six months of - within six months to come up with a revision to some standards. That's subsection (1)(o) in the Code, 22215(1)(o), and we had received a suggestion from a group of individuals that said this revision of standards could fulfill that need to take a look at within six months a geographic distribution phase. The language in (9) there on line 54 through 62 indicates that as the Commission was instructed by counsel, Attorney General at the last commission meeting that considered these standards, that we could not vote on a standard to acquire a CON for something that Public Act 619 specifically exempted from the CON to take final action, but what this does is it makes final action on this standard, should the Commission consider that something it wants to do. It makes this final action conditioned upon either a court of confident jurisdiction rendering 619 in from or a legislative - and I believe more likely a legislative appeal of the total-sum language in sub-section 3A, B and C. The department has had a long concern with sub-section 3C in particular which allows transfers potentially between any hospitals in the state. I have not seen an overwhelming number of interest on that, although we do have some interest in those

transfers that is beginning to surface. We would like to push hard for a repeal of sub-section 3C in particular, but perhaps all of 3 if a standard is adopted to accomplish limited transfers that the legislature had intended in 619, and that, of course, was the purpose of these standards. So what subsection (9) does is it says that the standard, if you decide to take final action on it, has a contingent future effective date, and that future effective date is either a final court decision or a legislative repeal. We frankly would like to do the legislative repeal and have then dialogue with the leadership - the CON Oversight Committee and the legislature once - when we sent this standard, and they've indicated to us that they would be willing to work on a legislative repeal of 3C and - 3A, B and C, the entire sub-section 3 that's been troublesome, if we can accomplish what was the legislative intent for the limited transfers. The next section in the standards - actually it's on page nine, and we had received comments that the standard as it was originally drafted and sent out by the Commission was open-ended. There was no time limit in which these limited transfers would have to take effect. And so there was a new section added on lines 419 there, sub-section E, that says that these standards shall expire on December 31st of 2008. What that does is put a limited five-year window in place under which these transfers can happen, and then these standards move out, so it isn't as though someone could have a commitment or an ability to make a transfer under the standard, and it would be wide open. There was a great deal of debate as to how long that window should be. Some individuals and groups had recommended the window at ten years. Others had said that's entirely too long. Three years would be more appropriate, make it a very tight - a band in there. The compromise was five years as it stands now under which these transfers could take place. The existing law did not have any limit.

MR. GOLDMAN: I'm sorry to interrupt.

MS. TURNER-BAILEY: Commissioner Goldman.

MR. GOLDMAN: Can I just get a technical clarification, Jan? The language on page two says the - referring to the date it goes into effect until a specific event, final decision by a court or repeal.

MR. CHRISTENSEN: That's correct.

MR. GOLDMAN: The language that you just read on page nine says - is this correct that the language on page nine says, if these standards go into effect because of a repeal or a final decision, they only remain in effect until a date certain, in this case December 2008?

MR. CHRISTENSEN: That's correct.

MR. GOLDMAN: So if the final decision was December 30, 2008, they would be in effect for a day, and that's nothing that we can control because we don't know when, if at all, the legislature would repeal, and we don't know when the court would reach a final decision. So what if instead of a final decision, there's a settlement; then what happens? I mean, there are some circumstances that we are not able to control, and I'm just trying to figure out when the requirements would activate and when they would come to an end.

MR. CHRISTENSEN: It's clearly the department's desire to do a legislative repeal if the legislature is inclined to do that. Our belief in conversation with the legislative folks that are in the relevant committees that would have to sponsor this, that they would be supportive of that. We also believe that - and know based on conversations that the executive branch would be strongly supported of it as well. So our view is that there is a will in the legislature to do the repeal but only if the limited transfers of the legislature had intended under 619 can be accomplished. I think there's general agreement in the legislature that as they wrote 3C, in particular in the legislative process, that it is much broader than they had intended it to be, and they would be willing to - at least in terms of the leadership that we've talked to, willing to sponsor that type of thing. They knew the legislative appeal is that you may get more stuff added in, so it would have to be a strong agreement between the executive and legislative branches to say a straight line repeal one section, section three, the troublesome one, the mistake that was made, if we can call it that, we're not offending anyone, in 619 it has caused so much deliberation on this council and this Commission and within the department and within the field to get at least this piece of the legislation cleaned up. I can't specifically speculate what the answer would be to a settlement. I can't feature a way in the current court case lead to settlement, but it's more likely to lead to decision on law at least based on information that has been decided and presented so far, but presumably settlement that would allow the limited legislative intent to occur and render the issue resolved not to go forward with legislative appeal with subsection 3, but the main thrust of that provision on 419 and 422 was to limit the total window of

opportunity to a narrow window of opportunity. A lot of the changes that are on pages ten and eleven are changes that attempt to bring the language back into sharper focus with the original intent of 619, so, you'll see we've added language that talks about in a city of 750,000 or more. That language is in the original one. We have included language that limits the dates by which the transfer's to be made. There is language towards the bottom of page 11 on lines 560 and 561 that, again, greatly restrict what was in the original legislation. Theoretically someone could have transferred up to an unlimited number of beds to a FSOF or to another hospital site, and there was no specific cap on it. This specifically caps it to the health system or system of hospitals, so that it's not 200 from each hospital or 500 total or anything like that. It's very clear that each hospital system that's involved in transferring a maximum of 300 beds forward. The language that's on line 569 through 579 attempted to address a problem that was raised in that - in - with respect to one transferring in Oakland County, we're actually transferring beds or potentially would transfers beds not from Detroit but from Oakland County to another Oakland County FSOF, if it was a hospital that would be in the same subarea, so it's a subarea transfer that the Commission has recently approved subarea, transfer to hospital to hospital within the same subarea. And what this says is that if a hospital or health system out of Detroit that has a hospital in Oakland County uses Oakland County beds to transfer into that FSOF but does not transfer all of its 300 cap, say it transfers 290, then up to an equal number of beds, which would be the ten remaining beds, they could move to another system. Now, the overall cap is 100 beds. So if they only move 200 of their 300 cap beds as a health system to the FSOF, if they move 200, then they can move 100 other beds under the same transfer that the other health system has, which can transfer from hospital - licensed hospital to licensed hospital. There was an attempt to equalize or make more fair the opportunity for the three affected Detroit Health Systems, and it does allow an additional - up to 100 beds transferred if they do not transfer all of their 300 cap to the FSOF. If they do, then there's nothing left.

MR. YOUNG: Jan, is that change only - wasn't it 200 in the past or -

MR. CHRISTENSEN: That was to date, what is the actual number that was the intent in the standard.

MR. AJLUNI: One interpretation that has been discussed or talked about would say that the one - one bed for every - one for every two beds has to be an act of - there's a provision 619 that up to a maximum of 100. If you read that as a cap, you would come up with 200. The debate has been that the legislation doesn't talk about that at all under 3C. There's nothing under 3C in terms of the cap. So we went back to the legislature leadership, and I think they have also sent communication from the co-chairs of the House and Senate Committees to the commission that indicates that had did not intended that to be an absolute limit of 200 but rather approximately 200 or somewhere around 250. We looked at the legislation. We don't believe there is a cap in it from the department's standpoint. And the compromise was 300 that we wrote into the standard. Now, that is a limitation, and I can say that I can't find anybody that likes that number 100 percent. There's reasons to push it higher and there's reasons to push it lower. The proposals were 500, 600 beds, 300 under each sub-section B because they had to FOS and sub-section C to a hospital. The department, in an attempt to (inaudible) limited and find certainty, it appears the commission would have a certain cap against which they could feel comfortable shows the number 300 based on all the testimony we received as an absolute cap, and the system with the legislative intent, as we could determine it in talking with the leadership that was involved at the time and correspondence from them. The language in sub-section 8 there on 587 and 589 basically parallels for Section 8C the same language that we had up under Section 765, that cap of five years. It basically says that - let's provide some certainty to the system as a whole. Let's close it off at five years regardless of what happens. The legislative appeal for whatever this standard is not going to be in effect after December 31st of 2008. The language that is shown as a strike-out on 589 and 562 is actually moved up to another section that - where it is more relevantly placed. That is up under sub-D in the page before that, so that language didn't actually change. It's just clarifying words to the transferring hospitals, but it was moved up to be in the right section that it relates to. It was originally placed in the wrong section. So those are the changes that are made in the standards based on the testimony that we received at the public hearing and hours and hours and hours of dialogue with lots of interested individuals, and it represents a standard, I think, that accomplishes the limited legislative intent and one in which it allows them to move afford with an repeal of the broader section 3C that we want to get out of legislation and off of the back of the Commission.

MS. TURNER-BAILEY: Thank you. Any questions? Commission Ajluni.

MR. AJLUNI: Commission Ajluni. Jim, had there been request for bed movements since our last meeting that would be impacted upon by these revisions and how would they be dealt with in terms of tightening the language in Part C, as you mentioned?

MR. CHRISTENSEN: Well, we've done an in-depth analysis now of all the requested transfers that we had, and originally it appeared that there was some bed movement in addition to the two transfers to the FSOF which are - which have been requested already on our part of the litigation. We had come up with four transfers where we had received Letters of Intent, but at - on our review, it appears those transfers are subarea transfers consistent with the standard that the Commission had approved in the previous months. We have identified two other transfers that are possible, and hospitals have confirmed with us that they're in dialogue about those transfers. We've not received any paper that they would appear to be transfers, at least one of which would be transfers within an HSA, it would be a subarea of the city transfer. We've not received candidly a flood of applications under 3C. And we have potentially one, possibly two that would be affected by that. But the possibility remains among remaining hospitals that this could be a mechanism for doing business in terms of ownership of hospitals and transferring within HSAs, and our estimate is that there are potentially 80 hospitals that could make transfers within HSA with multiple thousands of beds involved. I don't know that that will happen immediately but it could well become a mechanism or way of doing business as some of the hired guns, which I hate to call them because they're my colleagues in the bar, but some of the lawyers get involved in figuring out how to structure business entities. The department very much would like to get 3C off the books.

MR. AJLUNI: In the time between now and when and if C3 does get off the books, I guess that's the point of my question, how do we deal with requests for transfer; would they be dealt with according to the existing C3 in effect without being tightened up, wouldn't that be logical and might we end up with some hospitals in limbo as the language presumably gets tightened?

MR. CHRISTENSEN: Oh, I agree. I think we are in a vacuum right now, and I think as we - if we get requests under 3C, I don't have a basis for turning them down at this point. It's not an injunction against 3C. It's not a - it is a matter of statute. If we get one in, I would not know the basis for turning down a 3C transfer; and the longer it stays open, the more time that organizations and entities like health systems can begin to figure out things that might be to their advantage to use in 3C and to get their oar in the water, as it were, which is one of the reasons why the department has felt some sense of urgency. We, of course, want thorough discussion, but we have a sense of urgency to move as rapidly as possible with the legislative process that puts this frankly what I think everybody agrees was a mistake in 619 as it was passed in December, to close that option off before if becomes an entrenched vehicle where lots of people are involved in it, and then legislative support dwindles because people have an interest in seeing that it continue.

MS. TURNER-BAILEY: Did you raise your hand Commissioner Young commission? Okay.

MR. YOUNG: I guess my question is that many of the commissioners did not receive these proposals and didn't have any time to study them, and might be uncomfortable in making that vote or making that determination as soon as you'd like. I mean, what is your thoughts about that?

MR. CHRISTENSEN: I was informed this morning that for reasons that I haven't yet figured out, although we sent it out by E-mail and we didn't get it returned to us, a number of commissioners did not receive the standard by E-mail, which we had hoped they would, and we certainly want a fair process. I think if the commissioners and the chairperson has noted that there might be some interest in calling a special meeting to deal with this issue, I think as long as that happens fairly quick, and by fairly quick I mean two to three weeks because what it takes to get legislation moving is the LSD to draft a bill and for agreements to be cut with the legislature on both sides and it makes an executive branch; and in order to do that, we have a couple of - a three or four week process there at a minimum to get it through the LSD even if it has a priority, and I believe it would have a priority, it would have a priority from the executive branch to move it through. In order to get that done in a timely way before it becomes very, very politicized and to do very quickly and before we have additional amendments and other things that people want in that code changed, we need to move quite rapidly. So if the commissioners feel that the issue is of such a nature and that the changes - basically tightening up changes are changes that need a little more deliberation, a little more time on the part of the commissioners to have available than today's packed agenda, a special meeting in two to three weeks would be appropriate and would be strongly supported by the department.

MS. TURNER-BAILEY: Commissioner Breon.

MR. BREON: Jan, could you explain to me, just help me clarify this, the connection between a legislative approach and our approving of standards, what's that connection? Is the legislature going to look at what you've just distributed and say this is what we want, and then do we have any authority then to vote on the standard? I'm confused about that. I got confused last meeting and it's a hold-over from that, I think, but could you explain the connection between the legislative action and what we're going to be asked to vote on.

MR. CHRISTENSEN: I think it's a question of whether the Legislature felt that the intent that they were trying to accomplish in 619 was in fact carried out. I think we got 619 because there was a strong feeling in the legislature and even you can argue it was a lame duck session or it was a small majority of legislators voting. Unfortunately it is the law; it is 619, and it's on the books. I don't get any feedback from the co-chairs of the Health Policy Committee and the House and the Senate - in fact, I get actually the opposite feedback from them that they would go ahead and repeal 3C and then leave - or 3A, B and C, and then leave for some undeterminate time a deliberation about the intent they were trying to accomplish on 619. On the other hand, if the intent they were trying to accomplish, although not as precise and focused as it perhaps should have been, if the intent they were trying to accomplish with the limited transfers and the assistance and the (inaudible) mix of the Detroit-based health systems, which would in some part be remedied by this, if that intent was carried out, they would no longer have a legislative need to preserve 3A, B and C, and they would open to a repeal. That's frankly their position. We have 3C in there because there was sufficient leadership feeling about it. Some you went through the confirmation process and noted in the confirmation process that they -- some on that confirmation committee had asked that very same question in a lot of ways; are we going to be able to take care of the legislative intent that we as the elected legislative body in this state have made as a priority, and believe it's an important thing to accomplish for a public policy purpose, so that's the connection. I can't - I can't get a bill issued and voted on without their support. It's a separation of government. I can't do it from the executive branch to repeal 3C without their legislative support, and I have talked to them directly about it, and I think their letters in response to the draft standard that was sent out were pretty clear that they feel this standard that we're pushing through does accomplish it, although they want some additional conditional language in it. I need to talk to them about that, but you could apply a voluntary - a voluntary standard. I'm not sure that the department will support that but I need to get back with them on that, but I think unless there is a standard, I don't think we have a chance to legislative repeal, and I think regardless of what happens in the court case, I think 3C is probably out there. It needs legislative repeal. I don't think you're going to get a court to repeal 3C. I'm not sure of the basis for it if there is one.

MS. TURNER-BAILEY: Mr. Smant.

MR. SMANT: I don't know if you want to answer. It might be more of a comment than a question. What we have then is somewhat of a run-around than normal procedures and in how we draft these standards, who dictate from the Legislature, and I guess to me that's very onerous. I can act politically naive and say that in fact 3C is as bad as we all think it is, and maybe they do too, they still refuse to take action on it unless we acquiesce to what they put in 619, so it's a statement, you don't have to answer it, but I think that troubles me greatly. I see that as having dire consequences for the CON Commission anytime a legislature has an issue that they really bring to us in the future.

MR. CHRISTENSEN: I think I can comment briefly, if it's okay. In defense of the Legislature, they put a lot of things in 619. They said we needed to make changes, and largely a lot of those changes were a result of the audit of the CON process that was undertaken which suggested some changes were needed including expanding the Commission to 11 members from 5, including deadlines and dates to do various things, including mandating the department taking enforcement seriously, and that we do something under enforcement, and giving us more penalties to utilize in the event we want to take enforcement, and they also put in subsection 3A, B and C; and A was the subarea transfer, which was agreed to by the Commission as good public policy. B and C is out there, and it's being debated by the Commission, and they also created a more aggressive stance than ever did a Legislative Oversight Committee and the responsibility to report the Legislative Oversight Committee on various standards that were being proposed, so what they said was that 619 is - we the legislature being elected by the people and having responsibility for public policy and law in this state agree that we need to be more involved and need to pay more attention. We agree the department needs to do more in terms of its abilities to enforce the CON to carry it out, any we also agree that there needs to be transfers that we have seen or at least we heard testimony at the time we passed this law were necessary to improve the Health Care payer

(inaudible) in Detroit, so there were a variety of things they did, and it does feel uncomfortable when we (inaudible) don't agree with or perhaps we don't agree with that we feel we have to adhere to, but they made lot of changes.

MS. TURNER-BAILEY: Any questions? Commissioner Maitland.

MR. MAITLAND: Commissioner Maitland. I was one of those who didn't get this until about an hour ago, hour and a half, and it probably was my fault because I think it was sent, but we had two attachments in the same E-mail and I opened the first one and thought I did a good job of getting that one and then never opened the second one, but I - you know, there's a lot of things in here and a lot of changes made in the meeting in June. At that meeting, as indicated in the minutes, I asked to have a special meeting to try to work through these and get some of this stuff done because I knew we had a lot of other issues going on too, and we didn't address any of those issues in June, and if we look at this standard now, I don't think we're going to get to any of these issues again at this meeting, so I'm going to move that we defer the review for hospital beds to some point in the future at the will of the Chair where we can make sure that we get all input from everybody involved; and if we need to make a few changes as a proposal - as proposed, we can do that with the knowledge that we studied it to the best of our ability, so I so move.

MR. DELANEY: Support.

MS. TURNER-BAILEY: Moved by Commissioner Maitland, supported by Commissioner Delaney that we defer action on the hospital bed language as presented to the a future date, which would probably end up being a special meeting. Any discussion?

DR. SANDLER: Yes.

MS. TURNER-BAILEY: Commissioner Sandler.

DR. SANDLER: I understand why people want to defer this. I don't have a problem with that so much as to when we're going to defer this, and I have several comments I wish to make. One, is that we've been advised by the department as to the urgency of doing this very briefly, preferably in the next two or three weeks, and I can see why we cannot do that. Two, I would like a date set if possible today because in a short time frame my two colleagues on my right, actually, are seeing patients and they have surgeries, et cetera, so we need to know as soon as possible, and I need to know as soon as possible for my own departmental planning; and three, it's - and Mr. Styka, can comment, it's my understanding from the original bill that in section 65 and 83, they talked about these standards applicable within six months of the bill becoming - which is April 1st, the bill becoming law; therefore, that would be by October 1st we would be talking about - before October 1st.

MR. STYKA: Well, there is a requirement in the amendments that are part of Act 619 that you revise - that you revisit the hospital standards within six months. It doesn't require that you adopt anything in specific or that you adopt anything. You may revisit them and then simply approve what's already there, but there is a requirement to revisit the hospital bed standards within six months.

DR. SANDLER: That in effect is what we're doing, we're revisiting them. We may not adopt them, but we would be revisiting them.

MR. STYKA: Right.

MR. YOUNG: Madam Chair, in this meeting, what's the composition of this meeting, are we going to have a public debate here or is it just going to be Commissioners or -

MS. TURNER-BAILEY: I have several cards from the public who - a few cards that want to make comments. Commissioner Breon.

MR. BREON: I guess I would like to support turning this on first, but I'd like to support the idea of - I would like to suggest as well as others that we do set a date, an aggressive date and get this thing over with or it will drag on for months and months and months, so I guess whatever that appropriate date is would be up to you, so I'd just like to suggest that we do set something up on a definite time frame because -

MR. SANDLER: I have a comment about the cards which you said. Certainly none of us should ever have a problem hearing from the public, but I really don't want to debate these standards that we'll likely not be voting on today anyway. Hopefully what I think you meant was - I hopefully you mean on only the - only on the motion before us about delaying them, not specifically on the standards because that would take place at the meeting where we would be discussing them, otherwise we'll never get through the agenda again.

MS. TURNER-BAILEY: I'm not sure I understand what your question is.

MR. MAITLAND: I think we agree.

DR. SANDLER: What I'm saying is that I don't think public comments should be on the standards now. Public comment should only be on the motion, not on the standards; otherwise we're not going to get through the agenda again.

MR. MAITLAND: My motion would include moving all discussion to some future date.

DR. SANDLER: Right. And public comment can be made on the motion but, please, not on the standards.

MS. TURNER-BAILEY: Everybody knows that I've always been reluctant to not let people speak who want to speak, and this is the discussion on the - this is not a discussion on the motion. And I don't know that us voting on the motion necessarily gets us to this point of whether she should take discussion on the language or not. Maybe we should complete - we should sort of complete the circle of the discussion on the motion and the vote on the motion and then talk about whether we want to, as part of our agenda, take comments - take public comment on this particular issue. Ms. Hagenow.

MS. TURNER-BAILEY: Oh, I'm sorry.

MR. STYKA: As your parliamentarian, you're not required to have the public comment at the point of the agenda item. You could do it at the end. So, as I understand the motion that was presented and seconded, it's to defer this item to another meeting, including discussion on this item. That, of course, would not preclude people at the end from making public comment on this item if they choose.

MS. TURNER-BAILEY: When we take sort of just general public comment?

MR. STYKA: Yes.

MS. TURNER-BAILEY: Okay. There's a motion - I'm sorry. Commissioner Hagenow. I forgot that fast.

MS. HAGENOW: I want to comment on in lieu of putting the special meeting - I'm getting specific about that because it seems to me that they're - right now the department has done enough work with the legislature that they should have or they have the potential of creating what I would call a win/win situation in terms of their intent and honoring our role as a Certificate of Need in setting the standards for bed transfer. So if we keep deferring and it's not that important, it gives me a notion of well, you know, if I default something will happen. And if we are taking our leadership, we should review these carefully, listen to the comment and then take a vote within a very timely fashion because otherwise it's sort of - does play along with the idea that the legislation will make a decision, and they're ready to work with us at this point on setting the standards is what I'm hearing.

DR. SANDLER: I'd like an amendment to the motion, please.

MS. TURNER-BAILEY: I don't think - just to say - I don't know that we can sort of come up with a date. I think we can agree that we want to do it as quickly as possible. I mean, clearly there has to be arrangements made. We have to know where we - where and when we can get a room. I think that's probably the biggest barrier of anything, followed very closely by the commissioners' individual schedules as to when we can schedule a meeting, but certainly - I don't think we can say we can walk out of this room today with a meeting date, but that we can try and aggressively set a meeting date within the next –

UNIDENTIFIED SPEAKER: 30 days.

MS. TURNER-BAILEY: 30 days.

DR. SANDLER: I'd like to have an amendment, however, to the motion. My amendment is that a meeting take place within three weeks of today's date as was recommended by the department, and that would be in keeping with the spirit of this deliberate body.

MR. BREON: Support.

MS. TURNER-BAILEY: It's your -

MR. MAITLAND: Yeah. No, no, no. I don't have to accept an amendment to a motion. That's a motion - an amendment has to be voted on separately.

DR. SANDLER: He only has to accept them when it's a friendly -

MR. MAITLAND: Yeah.

DR. SANDLER: - amendment. And he doesn't consider that to be friendly.

MR. STYKA: That's my point. If he accepts it.

MR. MAITLAND: I want to vote.

DR. SANDLER: Is there a second?

MS. TURNER-BAILEY: There was a second. Thank you. Okay. Now we're to vote - I'm sorry.

MR. SMANT: We're discussing the amendment?

DR. SANDLER: Comments on the amendment?

MS. TURNER-BAILEY: Comments on the amendment? Commissioner Smant.

MR. SMANT: I don't have a problem with the three weeks, but what do we do if in fact they don't have a room or we don't have a quorum?

DR. SANDLER: Obviously we couldn't meet.

MR. SMANT: Well, I just wanted to make that fact.

DR. SANDLER: And my amendment is -

MR. SMANT: Based on your previous statement of the difficulty of fitting things in the schedule, I have no problem with an aggressive schedule but I think we need some flexibility because of -

DR. SANDLER: I can - thank you for that. I'll make a technical change. Three weeks if possible.

MR. SMANT: Fine.

MR. STYKA: Does the senator accept that?

MS. TURNER-BAILEY: Any further discussion on the amendment, trying to schedule a meeting within three weeks if possible to then discuss the hospital bed language? Any discussion?

MR. HORWITZ: Madam Chairperson, do you take public comment on that specific motion?

MS. TURNER-BAILEY: Yes. I don't have any cards on the motion but raise your hand and I'll try and -

MR. HORWITZ: I wanted to applaud.

MR. NASH: Identify yourself for the court reporter.

MR. HORWITZ: Oh, sure. Larry Horwitz, H-O-R-W-I-T-Z. I'm the president of the Economic Alliance for Michigan. I want to applaud what's seem to be the developing opinion within the Commission to - not to take action today. I want to speak to the question of how soon is whenever. The net result of your taking the action prior to the court case is to subvert the court case. I think that's something that the Commission should take into consideration. Why do I say that? If the plaintiff hospital - you know, do you really want to be in a position where the Commission is attempting to block people's ability to bring a lawsuit or to pursue their lawsuit? If you - if the judge decides that the plaintiff hospitals were saying this was illegal, and he says they're right, and that for a moment blocks the transfer of the Detroit Hospital Systems' beds to other places, then very - then as an automatic reflex of that, they get to be able to transfer beds, not to the extent that the statute does, but to the fullest extent of their desires, so that you set up a situation where if the Detroit hospitals win the lawsuit, they get to go forward. The Detroit hospitals lose the lawsuit, they get to go forward. This is called heads I win, tails you lose. It seems to me a rather unseemingly process to do. What then is the reason for moving this so quickly? The argument that was given to us by the department was that we have all these four C's things going around, and we checked it out, and we've gotten down to there's only one 3C issue around; right? All these other applicants were all subarea transfers. It doesn't seem to be a flood of them. We had been concerned about this. We raised it along with the department, but we don't think it's something that should cause you to flood through this approach. There needs to be time. I would hope you take testimony today on what's going on here and to know what's going on so we're not again in a situation where at some meeting it occurs for the first time hearing public comment. This stuff keeps changing. I got invited to a meeting last Tuesday by the department to talk about whatever this - Wednesday this was. They met with the Detroit hospitals and us, but not the plaintiff hospitals. This is a program, this does deal with substance, but it also therefore deals with why you want to take time and deliberatively consider this. Under this current language, which is new even from last Wednesday, DMC gets to move 300 beds, Henry Ford gets to move 300 beds and the Ascension System gets to move 399 beds. And the way this is structured, that permission could flow not just to the St. John System but could flow to any of their other subsidiaries, not Genesys. They're all in one sub area, but it could flow to the St. Joe Tawas System, it could flow to the Borgess system. There are technical problems here. We - that's a very different piece that's going on. If you're going to go ahead and do this because if you do it the legislature will do something, I think there needs to be a opportunity for direct dialogue with the legislature and the governor that if you repeal this - that if you do X, they will do Y, because it would absolutely be horrid to think you go pass the standard and then the vehicle through which this standard might take effect is another Christmas tree vehicle, because the vehicle that repeals it would get rid of it. We're told by the deputy director that he thought the governor would commit to veto anything that's included in (inaudible) other than a clean repeal, so he couldn't speak, she would have to speak for herself, got to talk with (inaudible) leadership, which means not just the committee chairman but others. I think that needs to be looked into. We clearly are concerned and troubled by this whole enterprise; all right? There are other groups; Chamber of Commerce and the AMA have sent you letters saying they think this is very, very bad for health care costs, that sort of thing. I think you need to have this done in a deliberate fashion and urge you to wait on this until after the court case. If you and do this therefore in late October - the judge has says he's going to decide this October 9th or shortly thereafter - what have you lost in terms of time? Well, the standards you submit can't even take effect until somewhere in mid-November at the earliest. Remember you've got to wait until the legislature comes back, which is a couple weeks, then you count 45 days, so it can't be done right away soon anyhow. The six-month issue that Dr. Sandler talks about is a six-month target that you've got to do by January, it's not six months from the day the law took effect, it's six months from the day the six commissioners were all confirmed. The Attorney General has told us that that date ended up being somewhere in June, so six months - no. For Dr. - Mr. Corey, he didn't get the 60 day deal until we hit July, so that takes us to January. So you're taking up something and moving it forward that has significant impacts on various people. I want to urge publicly here what I've urged in the department all along is that - I mentioned this to Jan back - after June, get all the parties together. Get the plaintiff party - hospitals together and the defendant hospitals together and try to sit down and work something out, don't just have meetings where the Detroit hospitals all figure out what the best deal is each for themselves and perhaps special language. This 299 business is uniquely applicable only to the Ascension System, not Henry Ford and not DMC. They get more extra beds than someone else does. They get different flexibility than someone else does, and they can then move their beds - some additional beds out of Detroit to someplace else. The letter you got from the two legislators, they thought it was 200 beds.

MS. TURNER-BAILEY: Excuse me, Larry.

MR. HORWITZ: I'm just closing up.

MS. TURNER-BAILEY: Every time I get ready to say -

MR. HORWITZ: Yep.

MS. TURNER-BAILEY: You've got to move back from the motion - from the actual motion to sort of the issue because I need to ask you to -

MR. HORWITZ: I understand.

MS. TURNER-BAILEY: - comment on the motion.

MR. HORWITZ: I'm doing that because of the reasons why I think you need a deliberative time to consider this. This is more than appears on the surface and it's different, and I think there needs to be a little bit of time, and I urge you not to do an action which completely ends up subverting the court process.

MS. TURNER-BAILEY: Thank you. Any questions? Thank you. Yes. Mr. Christensen.

MR. CHRISTENSEN: Jan Christensen, Policy Director for the Department of Community Health. We believe and would support that there is an urgency that we do need to be deliberative. The commissioners haven't got - we would urge a vote today, but if you weren't able to get the E-mail, we certainly understand the need for a deliberative process. We support the motion with a fixed time limit. Within the time limit of the motion it will be in my view relatively easy to get the assurances that we need from the legislative leadership and from the executive branch, if they're get-able. If they're inclined to agree, as we believe they are to a single straight clear repeal, I think we can get enough of an answer on that within two to three weeks without much difficulties. As I say, the current policy chairs of the relevant committees have said they would be supportive, so I would add that we can do this within that time frame. If you delay into October, what you will do, I think, is risk additional transfers under 3C which may not - and if they come through, they would be approved because we don't have an ability to stop those. And, in addition, depending on the result of the lawsuit regardless of who wins it, the other party in the lawsuit would be less likely to want to be in a negotiating mood with is it 300 beds or 500 beds. One party wins, hey, we don't need the standard. Another party wins, we need the standard, but the legislature would be less willing to make the changes that we want, so I think there is a sense of urgency, and I don't see this standard as preempting the legal arguments that the judge will have to make - have to make on the merits of the case. I think he will make the judgments. You could also run the same argument that whoever wins, it will be appealed to two to three years and that would give you reason to delay it for another two or three years. That kind of delay is very risky because it invites the legislature, it seems to me, to come back with another legislative solution that attempts to solve the problems that they were trying to solve when they passed 619, and it invites, it seems to me, more meddling into a decision which ought to be delivered within the CON Commission.

MS. TURNER-BAILEY: Commissioner Hagenow.

MS. HAGENOW: I just want to reiterate again, why would we default to somebody else to make the decision when we're the ones who set the standards, and we now have the legislative intent very clear, and it sounds to me like a very clear potential win/win in the honoring of that legislative intent and setting the standard. So by default, giving that up, does not seem to be allowing anything better to happen on into the future but probably greater procrastination in two to three years or whatever time, and that's the fault that I heard of the CON is that there is a constant bureaucratic putting off of that which is needing to be responsive to the public, and so it seems to me that the 30 days or whatever the time line - and I think we have to be reasonable about that - but we should get it done because of the value and importance of what we do.

MS. TURNER-BAILEY: Any further comments?

Madam Chair, would you take another comment from the public?

MS. TURNER-BAILEY: On the motion? On the motion, yes.

MS. TURNER-BAILEY: Raj Wiener with Wiener Associates. I represent - actually, this is three of the hospitals that are in the City of Detroit. I want to urge you to take expeditious action as a Commission on this agenda item. I understand that you may not be comfortable doing it today, but to deliberately delay this discussion until after a court date, which is only a date for making motions for summary disposition, it's - you know, it's just one date in a series of dates and appeals. You could be asked to do that over and over again. And I was at the meeting where the department called in the three hospitals and called in Larry and extracted a lot of limitations from the hospitals who agreed to go with it in order to get back to the CON process and have this Commission deliberate and act on this. I've been involved in some of the legislative discussions and independently where the legislators felt the need to comment on this because it's a new part of the law, not because they were trying to interfere, but they had a report from the Commission, so I think it would be a serious mistake to delay, specifically to wait until after this court date in October. That's as arbitrary as anything. You are the CON Commission, and I think you should take action, and if you could call that meeting as soon as you can, I think everybody would be better off. Thank you, Madam Chair.

MS. TURNER-BAILEY: Thank you. This card that I just got - (A pause in the proceedings.)

MS. MAHAFFEY: This is public comment on the question of deferral of the action; am I correct?

MS. TURNER-BAILEY: And the time frame?

MS. MAHAFFEY: And the time frame, yes. I would like to speak. I'm Maryann Mahaffey. I'm President of the Detroit City Council.

Member Watson who was with me in June could not be here today and asked me to speak on her behalf as well mine. I am in favor of the delay, and I am in favor of waiting until the court makes a decision because I think it is improper knowing there is litigation to act before the litigation is resolved. I also must say that I find it very difficult to believe that public discussion means politicizing of an issue. I speak for people who have great needs for health care who have difficulty often times getting access to health care, and I think this is an issue in a democratic society that deserves to have debate including on the part of the people who will be affected, not just those who deliver the service, and so consequently I speak in favor of the delay, and I speak in favor of waiting until the litigation has been resolved because it seems to me that's the way it ought to work in this society. Thank you very much for giving me this opportunity to express an opinion for those of us on the city council. Thank you.

MS. TURNER-BAILEY: Thank you. Any questions?

DR. SANDLER: I'd like to call the vote, please.

MS. TURNER-BAILEY: I think that's appropriate at this time, and this is on the amendment to -

MR. STYKA: You have to vote on closing the debate.

MS. TURNER-BAILEY: I have to vote on closing the debate. Okay. All right. There's been - we have to vote on closing the debate. Do I have to take a motion on that?

MR. MAITLAND: No. He made it.

MR. STYKA: He made it.

MS. TURNER-BAILEY: All right. All those in favor of closing the debate, signify by saying aye. All opposed? Those in favor of scheduling the special - a special meeting with three weeks or soon thereafter -

MR. STYKA: No.

DR. SANDLER: That's not - three weeks if possible.

MS. TURNER-BAILEY: If possible. Okay. If possible, please signify by saying aye. Opposed. Opposed. You think I should do a vote - a hand vote. I'm sorry. Pardon?

MR. STYKA: Just call for hands.

MS. TURNER-BAILEY: Yeah. I just need everybody to raise their hands just to make sure because we have to have six. Those in favor, please raise your hand. One, two, three, four, five, six. Okay. Those opposed? And there's three opposed. So six have voted in favor. The motion carries.

MR. STYKA: Actually, seven because...

DR. SANDLER: It was seven to four, I believe.

MR. STYKA: Commissioner Delaney as well as -

MS. TURNER-BAILEY: Okay. I'm sorry. I must have missed somebody over in the corner.

MR. MAITLAND: We need an official counter.

MS. TURNER-BAILEY: Which will be fine.

MR. STYKA: She doesn't have a good -.

MS. TURNER-BAILEY: Right. Yeah. I think I must have missed a hand over there because I thought I counted six. Anyway, six is - six is -

MR. STYKA: Six is all you need.

MS. TURNER-BAILEY: - all you really need anyway so - so that motion carries. And then - now we're back to the original motion, actually, which is to defer a vote on the language put before us - for some of us this morning, but certainly for this meeting, with regards to what was sent out on the June 10th. Do we need further discussion on that, do we? Okay. All those in favor -

MR. STYKA: That would be - now it would be to defer to a meeting that would be held if possible -

MS. TURNER-BAILEY: Within three weeks. Within three weeks if possible. Does everybody understand what I just said?

MS. ROGERS: Renee -

MS. TURNER-BAILEY: Yes.

MS. ROGERS: - for clarification because I know it was mentioned and I'm not sure, Jim mentioned - at one point mentioned that public comment would also be held over till that or is that not the intent, you want to clarify in that motion?

MR. MAITLAND: Well, we had that discussion. I understand that anyone has a right to speak, but I think if we do defer it to a future date, most people would probably remove themselves from public comment anyway, but I don't think we can stop people from talking at least during the right to talk at the public comment portion, so does that clarify?

MS. ROGERS: So earlier -

MS. TURNER-BAILEY: So that's not part of the motion then?

MS. ROGERS: So it's not part of the motion then?

MR. MAITLAND: Right, because I don't think personally we can stop people from talking.

MS. ROGERS: Thank you. This is Brenda.

MS. TURNER-BAILEY: All those in favor signify by raising your hand, please.

MR. STYKA: What's the -

MS. TURNER-BAILEY: The motion is to defer action on the hospital bed language that was put before us today. I shouldn't say that because it's not new language. This is the language as modified from the June 10th meeting to a meeting to be scheduled within three weeks, if possible.

MS. ROGERS: That's to modify the language -

MR. STYKA: No.

MS. TURNER-BAILEY: No. No, we didn't. That was in an amendment to the original motion, so it's sort of a mute point but we still have to take a vote on that. All right.

MR. STYKA: It's to move item 5 to a date - to a subsequent date -

DR. SANDLER: To a subsequent date.

MR. STYKA: - to be held if possible within the next three weeks.

MS. TURNER-BAILEY: Right. And I'm assuming you're assuming that if we voted to say within three weeks, then we also agree to defer, but we have to take the vote. So all those in favor signify by saying aye. Opposed? Okay. With one opposed.

MR. MAITLAND: Renee, I'm opposed too.

MS. TURNER-BAILEY: You're opposed to your motion?

MR. MAITLAND: I didn't say aye either time. I was still thinking, but I thought you were going to say raise your hands, so I -

MS. TURNER-BAILEY: Okay. Two opposition. I'm sorry.

DR. SANDLER: No kidding.

MR. STYKA: Do you want to make it - do you want to call for hands?

MS. TURNER-BAILEY: Yes, I probably should do that. We'll probably move to raising hands at all times. Can you just please verify your vote on the last motion for deferring vote on the hospital bed language by raising your hand. Those in favor, please raise your hands. One two, three, four, five, six, seven, eight, nine. Those opposed. Okay. Two opposed.

MS. TURNER-BAILEY: Thank you.

MS. TURNER-BAILEY: It's a little after twelve and lunch for the commissioners is ready from what I understand, and also I'm making an announcement on the behalf of Michelle Joseph of Kheder, Davis & Associates.

MR. STYKA: Kheder.

MS. TURNER-BAILEY: Kheder. Sorry. I think I do that every time. Somebody needs to write a phonetic spelling for me.

MR. MAITLAND: They're catering the event.

MS. TURNER-BAILEY: I got it. I got it. Kheder. I apologize. Kheder, Davis & Associates that lunch will be provided next door in the cafeteria for everyone other than the Commission. We are adjourned until 1:00. (Whereupon a lunch break was taken at 12:05 p.m.) (Back on the record at 1:05.)

MS. TURNER-BAILEY: Good afternoon. I hope everyone enjoyed their lunch from Kheder, Davis & Associates.

MR. STYKA: Officially mention that was not for the commissioners.

MS. TURNER-BAILEY: Not for the commissioners, I said that. At this point I'm going to reconvene the meeting. It's 1:05, and move onto the next agenda item which is item 6, 2002 PA 619 Sections Requiring CON Action. That's that list but - Brenda -

MS. ROGERS: It's under your miscellaneous -

MS. TURNER-BAILEY: Oh, okay.

MS. ROGERS: - tab - .

MS. TURNER-BAILEY: Thank you.

MS. ROGERS: - just for your information.

MS. TURNER-BAILEY: Thank you.

MS. ROGERS: What we supplied to you is the table that we presented at the June 10th meeting that gives, you know, a basic order of things to come. Some don't have deadline dates, others there are some pending due dates. What we are asking today is, as we talked about this - hopefully the Commission has had a little bit of time to maybe think about some of these things as to help guide the department in how it wants us to proceed on handling some of these items or, you know, and/or in what order. Just to let you know, to bring you up-to-date, there are some changes, specific changes to - that need to be made to all of the CON Review Standards, and specifically those involving the requirement - the Medicaid requirement and the definition of rural counties. What I'm going to do is, I've got some copies here and you'll note if you've looked at the CT language, those changes are already included in those standards that you'll be discussing later today.

MS. TURNER-BAILEY: Okay.

MS. ROGERS: What's coming around is the proposed language regarding Medicaid and regarding the rural county that we would need to make to add to all of these standards, so to give you an idea - and basically I've taken this right from what we've included in the CT language today. It would have to be included in the appropriate sections under each of the Review Standards. I've talked to Ron, and if we - if the Commission desires, we can make these changes in all of the Review Standards, move them forward to public hearing - well, actually - we can do it one of a couple of ways, I guess. We can put it in the language, bring, you know, each standard back to the Commission and take a look at, so you can take proposed action on because you may not feel comfortable just (inaudible) you know, having us move that forward, but once you take proposed action, then we would set up the public hearing; and in talking with Ron, we could set one public hearing for all those Review Standards as long as it was only these changes and/or technical changes that were being made to the standards. As you're aware, we currently have four standards on the Commission work plan; the litho, the CT, the MRT and a surgical, so those standards we would just combine this language right along with all the other changes that we're making to those standards, but then the remaining ten, eleven standards, we would go ahead make these changes and move them forward if the Commission so desires. There is an issue with the rural county definition, and that's taken right from the statute. Stan has gotten the information and put together the table that shows the changes to rural counties, and, again, I'm passing this list around. The counties in bold that you'll see on these lists are a change that were once rural counties and are no longer considered rural counties under the new definition under the statute, so this could potentially cause some problems in some of those standards where we referenced rural county.

MR. COREY: Do you have the names of the counties that were under the old rule, like -

MS. ROGERS: Those - yeah, they're already in here. Those counties in bold; okay -

MR. COREY: Oh, okay.

MS. ROGERS: - on here, they used to be rural. They are now considered could non rural.

MR. COREY: Thank you.

MS. ROGERS: So, you know, the Commission may want to have some discussion on this item at some point in time thereto, keeping in mind that I can tell you of the four Review Standards that we are working on right now, I know that lithotripsy does use the rural definition in its standards, and that's the next set of standards that we will be bringing forward to this Commission, so it's going to be something that is going to have to be considered.

MS. TURNER-BAILEY: Okay. So there's sort of two issues with regards to this particular item and that is, number one, do we want to go ahead and have you make the changes to all of the standards, and then do we need to have that brought back to us for a review prior to sending it out for public comment, which I personally would lean towards doing. And then the second question is, do we need - do we think we need to have a little bit more discussion with regards to the impact of these changes between rural and non-rural, which we could do at the same time of bringing back these changes for - towards - in front of the Commission? Is there a reason why we can't do that at the December meeting?

MS. ROGERS: No, there's no reason. I just wanted to bring it to your attention at this time so that way you as the commissioners can be thinking about this because this will be an item that will need to be discussed.

MS. TURNER-BAILEY: Is it something that we need to put on a work plan or can we just agree to address it at the December meeting?

MS. ROGERS: I think you can just agree to address it at the December meeting because we will have all of those standards available at that meeting for you to take caption on.

MS. TURNER-BAILEY: Okay. Question?

MR. COREY: I have one question. How did the criteria change or did the demographics change or what process would you go through to change from rural to non-rural?

MS. ROGERS: It's basically the demographics, and it's now based on the 2000 Census, from that, and they - under the Federal - their definition changed, that's why this is changed. They now have micropolitan areas, and if Stan's still in here? Okay. He is actually the person that could get to the specifics. He is the one that actually ran it and did the comparison, but that's what it came down to because the Feds changed their definition, and that's how come our definition -

MR. COREY: And we can get -

MS. ROGERS: - is changing.

MR. COREY: - we'll be able to get that information?

MS. ROGERS: We can supply that, yeah. We've got copies of what he - yeah.

MR. CORY: Thank you.

MS. TURNER-BAILEY: Do you have a comment?

MR. HART: Yeah, Madam Chair, the Feds have changed the - have created a new - a new - a group of counties called micropolitan statistical areas, and you might notice in that list that such considered rural areas as the Keweenaw County is identified now not as a rural county but as a micropolitan statistical area. The

difference is that the impact of the county next to it is what's being measured here in a nutshell, and there's quite a bit of concern among the rural health people right now. I happen to sit on the board of the Michigan Senate for Rural Health and we're very concerned of the impact this would have on what used to be the 58 rural counties in Michigan, so I would suggest that we have - at our next meeting I can have the Director of the Michigan Senate for Rural Health come in and make a brief presentation on the impact that the micropolitan statistical areas will have, not just on CON but all through - all through language that's in the state law, so this is - this looks quiet, but it could be a real big issue on rural areas. Now, some of the - some of the counties that were rural that are now micropolitan or are now metropolitan, like Newaygo, the reimbursements in Newaygo County for - for the hospitals there will be beneficial to them - to the hospital system, so there's a whole lot around this micropolitan and metropolitan statistical area now.

MS. BARKHOLZ: Madam Chair?

MS. TURNER-BAILEY: Yes. Are you -

MS. BARKHOLZ: Can I comment on that agenda item?

MS. TURNER-BAILEY: Pardon?

MS. BARKHOLZ: I just wanted to comment on that agenda item.

MS. TURNER-BAILEY: Okay. All right. I was going to call you but...

MS. BARKHOLZ: Sorry. I didn't mean to jump the gun.

MS. TURNER-BAILEY: Okay.

MS. BARKHOLZ: Amy Barkholz from the Michigan Health and Hospital Association. I just want to echo what Mr. Hart said about the impact. The use of this term "micropolitan statistical area," it kind of came on the hospital community a little bit by surprise, and I wanted to let you know that I've been getting a great deal of calls and E-mails expressing concern from these formerly rural counties that are now considered micropolitan statistical areas, so I just wanted to give you all a heads-up so that you know that if this is a discussion item for the December meeting, that it is an item of concern and that you'll have hospitals wanting to weigh in on this carefully because, you know, obviously many of the folks that currently fall within the rural category for many of these CON standards will not now. And they - they'll be negatively impacted by that. Just a heads-up to that issue.

MS. TURNER-BAILEY: Thank you. Any questions? Okay. So the December time frame, though, this says we are to add this requirement by January 1st, 2004. Does that put us in a position where we are not able to do that if we wait until the December meeting to get this language and to get this evaluation? I mean, I'm just trying to figure out can we do this by - is it done - if we agree on it in December, is it then completed for our January 1st time frame or is there an issue because we just talked about sending it out to public comment?

MR. STYKA: You're talking about the Medicaid language change, you know, because I was still thinking -

MS. TURNER-BAILEY: Sorry.

MR. STYKA: - it's a rural?

MS. TURNER-BAILEY: But we talked about making all of this language change sort of at one time so.

MR. MAITLAND: I think we have to do it now because then it has to come back at our next meeting.

MR. STYKA: As I recall, the statute did require that you do it by the end of the year.

MS. TURNER-BAILEY: Well, it says by January - well, this piece of it says by January 1st.

MR. STYKA: All right. Now, if you took your action by January 1, it wouldn't become effective, but at lease you'd have taken the action, so I think you'd be okay.

MR. MAITLAND: I mean, why can't we just take care of it right now, a motion accepting this and changing all the standards that haven't been previously changed and set it for public hearing and then you can set the date anytime between - I mean, why don't we just do it?

MR. STYKA: It's your pleasure.

MR. MAITLAND: We're not going to change the language, are we? The language is...

MS. TURNER-BAILEY: Brenda.

MS. ROGERS: Yeah, the language basically is that language for each of the standards now. Also, just to let you know what we were trying to do with these standards, too, is trying to clean up and making technical changes, like some of the standards define Commission one way and other standards define it another, so we're making those types of technical changes along the way, so if the Commission's comfortable with that, I really would like to still include those changes because we basically have probably 80 percent of the standards drafted with the language in it, along with the technical changes, cleaning up some of the standards still say Department of Public Health, so we're changing it to Department of Community Health.

MR. MAITLAND: Well, you've always done that anyway, and it does come back.

MS. ROGERS: Right.

MS. TURNER-BAILEY: Commission Hagenow.

MS. HAGENOW: What about the Medicaid and the impact or the effect on people? I mean, if we're just cleaning up standards and it's sort of just a bookkeeping thing, it's one thing. If this has big impact, is that different than what it currently is, the Medicaid one? I mean, what's - is it just a wording thing that's going to now be included or is there something that has an outcome content impact on changed practice and...

MS. ROGERS: It basically now, because of the way the statute is written, is now a requirement for all of our covered services with the exception of nursing homes. They did exclude nursing homes from having this requirement, so pretty much just adding that language into the standards to make it comply with the statute.

MR. STYKA: To try and answer your question a little differently, the legislature wants this Medicaid language or some version of it adopted before the end of the year so that it is - it becomes an actual requirement within the - at least six to twelve consecutive months within the first two years, etcetera, there's participation. That's different than the need in general for housekeeping and clean-up language within all the different...

MS. HAGENOW: It is a change?

MR. STYKA: Yeah. This isn't just a difference. It will effect the industry, the health industry.

MS. TURNER-BAILEY: Any other questions or comments?

MR. MAITLAND: Well, if we make a motion - I mean, we can't change this language; right?

MR. STYKA: That's correct. That's right.

MR. HART: It needs to go forward.

MS. TURNER-BAILEY: We can make a motion to put this language forward for public comment which is what has happened, not just this language but other technical changes that the department might see as being necessary, and then bring it back for final action at the December meeting; right? We could do that, which is -

MR. MAITLAND: I would move that we move forward to set up a public hearing of all the standards to include this Medicaid language and any type of changes that's necessary for public hearing as soon as possible.

DR. SANDLER: I'd like to second that.

MS. TURNER-BAILEY: It's been moved by Commission Maitland, seconds by Commissioner Sandler that we move the Title 19 requirement language, put it into the - into the standards as well as other technical changes that need to take place, and move that to public comment. Any discussion? Commissioner Goldman.

MR. GOLDMAN: Yeah. Would that include all the language on - recommended language, both the Title 19 language and the definition of the rural counties as set forth in the federal guidelines?

MR. MAITLAND: This page, yes.

MR. GOLDMAN: Okay. Because it sounds like there's three different things happening; one is that there are some technical amendments changing Michigan Department of Public Health to Michigan Department of Community Health and changes of that nature. The second thing that is happening is that we will be requiring, with the exception of the nursing homes, any applicant to participate in Medicaid, and we are doing that pursuant to a directive from the state legislature; and the third thing is that we will be updating our requirement of what is a - what is rural and what is non-rural, again, pursuant to a federal requirement, but that will make some changes in who can apply for - under other of our standards, so I just want to make sure everybody understands that there are three different things going on here.

MR. MAITLAND: Well, wait a minute. The deadline for January 1st only has to do with this Medicaid. This page, this - I'm not talking about -

MR. STYKA: Correct. No -

MS. TURNER-BAILEY: But there's language in here that -

MR. GOLDMAN: But the second part of that page effects the grid in your right hand.

MR. STYKA: The language on rural county, you do not need to take action on today.

MS. TURNER-BAILEY: Okay.

MR. STYKA: And since that may affect different standards differently, you may want to - you might want to do that at the same time you do all the other changes the department wants to make to clean up these things.

MR. GOLDMAN: So to keep in compliance, we could move the top half of -

MR. STYKA: Yes.

MR. GOLDMAN: - the suggested language page and leave for another day the questions of whether we should call the Michigan Department of Community Health the Michigan Department of Community Health, and what we should do in terms of rural counties. We might not have a lot of room but I would like to hear public comment because if you look at the - Section 3332207 of subarea of PA 619 defines rural county based on the United States Office of Management and Budget definition, so we may be sort of deprived there, but I'd like to hear comment before I go ahead with that, so I guess my suggestion would be that you could move the Medicaid definition so that that could go forward. You may also want to move the rural county one just to get the public hearing, but that part I don't believe has to be done by January.

MR. STYKA: Yeah.

MS. TURNER-BAILEY: But the motion is to move the whole - the whole thing forward; I mean, whether you want to modify your motion -

MR. MAITLAND: Well, I can certainly - if that's a problem, I - I assumed that the definition of micropolitan statistical area was something required too, but if it isn't then…

MS. ROGERS: It is part of the new definition.

MS. TURNER-BAILEY: Take the microphone.

MR. MAITLAND: The requirement that we have on January 1st seems to only be the Medicaid Title 19, so that's - I would - if Dr. Sandler would support my change of that, just to include that -

DR. SANDLER: I would be delighted, Commissioner Maitland.

MS. TURNER-BAILEY: Amy Barkholz.

MS. BARKHOLZ: I would urge the Commission to support that changed amendment or changed motion, and the reason is, because there is a great deal of concern about this micropolitan statistical area to ask the department to go through and retrofit all the standards to adjust to that when you'll have a lot of hospitals likely asking you to find a way to make the standards apply to the same rural areas including mainly the Traverse City area that's affected, it seems like it makes sense to have the public hearing and find out what can be a done to accommodate this. I think the biggest problem was in PA 619, that word "micropolitan statistical area" was added in there. I should have caught it, others should have caught it and said wait, this is going to be a huge problem if you add this into the statute. We didn't do that because we did not realize that that meant that many of our rural counties right now would be bumped out of being considered rural in our current standards; so if we can have a public hearing and try to figure out if there's a way to work around that with the micropolitan statistical definition, MHA would really support that approach. Thanks.

MS. TURNER-BAILEY: Okay. Can I just understand what you just - because you sounded like you - you wanted not to - not to move the language. I thought you started by saying you didn't wanted that part of the language moved forward -

MS. BARKHOLZ: What I -

MS. TURNER-BAILEY: - to public hearing.

MS. BARKHOLZ: - what I understood Mr. Goldman's clarification was move forward having the department make changes to everything except for, among other things, the rural issue, which counties would now be micropolitan statistical areas, and if that's my understanding, I would say that is an approach that makes sense because of all the concerns that the hospitals have, having the department go forward now before a public hearing and doing a lot of work to say all of the standards now apply to counties that are not micropolitan statistical areas would mean that we would have a lot of hospitals and the MHA coming up opposing what the department went through all this trouble to do, and I didn't want them to go through that extra work if there was a way in the public hearing where we could all come up with a solution that both met the Federal requirements and allowed the hospitals that currently are in the rural definition to remain in the rural definition, and I think there's a way to do that, so that's what I was hoping you would come to a conclusion to do.

MS. TURNER-BAILEY: Okay. Thank you. Larry Horwitz.

MR. HORWITZ: Larry Horwitz, with Economic Reliance. I did notice this. I spoke to Senator Schwartz's aide about this and what they were trying to do and urged them not to do it because it had all kinds of unclear consequences. Senator Schwartz was - I heard back in the very helter skelter of the end of the last session was bound and determined to do that. Okay. I believe the following is true, however, that the definition of rural county is a definition that's applicable in the statute. If you look in the statute as to where rural county occurs, it occurs for compare review relocation of a hospital. If you're in a - well, in fact, I'm not even sure whether rural county applies - can be found as a term of art in here. I don't think it is necessarily true at all on raising this so Styka and others can think about this and look at it. When you want to, in the standards, treat what you think is rural different than what you think is not rural, I do not believe that you're bound by the fact that the legislature said that the phrase "rural county" means the following. You can decide that you still want to have Traverse City continue to be treated as the same way Menominee County is or something, and I believe you can do that. You

couldn't use the term "rural county" because the statute says the term in here are - the standards often say that we use the same terms in the statute, but I still think you can distinguish between different parts of the state according to what you in your best judgment think, so I'm not terribly sure how urgent a problem it is, but in order that you have an effective parliamentary vehicle to do whatever you need to do, I certainly would propose that you do include it in what goes to public comment so that if in December the judgment is made contrary to my interpretation of late in the evening of last December that this wasn't as big a problem as I thought it was to deal with, then you have a vehicle before you at the December meeting to back up.

MS. TURNER-BAILEY: Any questions? Thank you.

MR. HORWITZ: I'm hoping that this stimulates people looking - whether this is a definition that's applicable to all standards or just to the statute.

MS. TURNER-BAILEY: Mr. Styka.

MR. STYKA: Generally a rule making - if a term is defined in the statute, it has to be defined the same was as stated in the rules. Now, standards are not rules but they follow many of the same adoption procedures, et cetera and are considered equivalent of the rules. So in - my initial reaction is if you are going to use the word "rural county" in a standard, you're going to have to be consistent with what's in the statute. That does not mean that you can't use some other term defined a different way to accomplish what you want to accomplish. But if you're going to use the term "rural county," you're stuck with being consistent with the statute.

MS. TURNER-BAILEY: Okay.

MR. HORWITZ: And my comment is if you decide to divide the world into urban places and non-urban places, you can define non urban the way you want.

MS. TURNER-BAILEY: Sounds like what you said. Okay. Can you repeat your motion, please?

MR. MAITLAND: I move that we direct staff to - that we proceed with changing our standards to include the new definition for Medicaid as requested by the legislature, and any other technical changes.

MS. TURNER-BAILEY: And you supported that; right, Dr. Sandler?

DR. SANDLER: Yes, I did.

MS. TURNER-BAILEY: Okay. So it's been moved and supported that we move - that we adopt and move forward for public comment the Medicaid or Title 19 language as indicated by the department and other technical changes that the department deems necessary. We're not going to deal with that other piece at all; right? Okay. All those in favor - I'm sorry. Anymore discussion? All those in favor please raise your hands. Opposed.

MS. TURNER-BAILEY: Okay. It passes unanimously. Thank you. Okay. We're going to move on to Item Seven, Hospital Beds Subarea Methodology Update from the Hospital Technical Advisory Committee. Dale Steiger.

MR. STEIGER: Good afternoon. My name's Dale Steiger. I'm with Blue Cross and Blue Shield of Michigan, and I'm going to make a very quick report on some pretty substantial progress that the Technical Advisory Committee has made recently. I'm sure you all know that the Technical Advisory Committee is sort of a subgroup of the Bed Need Ad Hoc Committee and our responsibility over the last 18 months or so has been to review and revise the bed need methodology as necessary and also to come up with a new - not a new, but to also revise the methodology that was used 15 or 20 years ago to develop subareas, planning areas, if you will, within the HSA's. Our group, as I said, has been meeting for the last 18 months. The last few weeks we've made very substantial progress in terms of refining the subareas. We've met the last two Fridays. We're going to meet again this Friday, and although I haven't mentioned it to the rest of the members on the committee, it's sort of my intention to keep meeting on Fridays as long as the department can keep up with us because our intention is to get this finished. I think given the progress that the department's made the - the last few months we really have been captives of the department. We can't go any faster than they can support us. They've

done a great job of supporting us the last couple of months, so I think that we're in very good shape at this point, and I think this effort will be completed and we'll be able to go back to the Bed Need Ad Hoc Committee probably within the next four to six weeks.

MS. TURNER-BAILEY: Thank you. Are there any questions?

MR. STEIGER: I'd be happy to answer any questions. Thank you.

DR. SANDLER: Just thank you for all your work.

MS. TURNER-BAILEY: Okay. Agenda item 8, CT. I understand that -

MS. ROGERS: This is Brenda Rogers. And Dr. Sandler was the Commission liaison for this set of standards. Just a real quick brief overview. At the June 10th meeting, the Commission agreed to try a pilot project this summer. We had four sets of Review Standards that need to be updated. We held public hearings on all four sets of standards. Liaisons, commission liaisons were assigned to those standards. Dr. Sandler was assigned to CT. Dr. Goldman to lithotripsy. Commissioner Hagenow to surgical services. And Commissioner Maitland to MRT. To bring you up-to-date, the CT standards, we have language that we are presenting to the Commission today, and I will let Dr. Sandler give a brief overview in just a minute. And lithotripsy, we are probably about 80 percent completed on the draft language. We'll be presenting that to Commissioner Goldman within the week - well, actually, by next week, and so that language should be coming to the Commission at its December meeting, and we are currently reviewing the public comments for surgical and MRT and will be starting the draft language on those and starting to work with the Commission liaison on those sets of standards as well.

MS. TURNER-BAILEY: Thank you.

MS. ROGERS: Dr. Sandler.

MS. TURNER-BAILEY: Dr. Sandler.

DR. SANDLER: Okay. Thank you. Here's an overview of the CT Standards Review. First, the request I worked with Larry Horvath on this and one of Larry's request was to look at project delivery, and to date I believe we did do that, but there are probably three specific changes that I'll bring to everyone's attention. The first one had to do with changing the standards to allow small hospitals, usually rural by both the old and new definition, I think, but at least hospitals in sparsely-populated areas, whatever you wish to call it, that they no longer will have volume requirements to have a CT or equally important in place a CT as long as they have 24-hour emergency rooms. The concept here is the standard of care does require a CT to be in a 24-hour emergency room - CT in the hospital anyway. It doesn't necessarily have to be in the emergency room. At the request of the department I did obtain documentation from the American College of Emergency Physicians, which is included in your packet of material, to document the fact there are numerous conditions, trauma being the most obvious, but numerous other conditions, subarachnoid bleed in the head, dissecting aneurysm of the aorta, diverticulitis, et cetera, where clearly an immediate CT would be the standard of care in the United States, and that documentation is there. That would be the first item. The second item is a - has to do with the PET/CT hybrid. PET standards were adopted by the Commission. Final adoption, I think, was in December of '01, and that enabled one to have certain standards to purchase a PET/CT hybrid. In the United States at present you almost cannot buy a PET scanner unless it's a PET hybrid. There's no market for that because the simultaneous scanning allows for localization of the abnormality. The PET/CT hybrid that you are purchasing or leasing or whatever, the CT aspect is a multi-detector system - I'll address that in a moment - that's the newest technology. I spoke with the General Electric people, it's either eight or 16. Most of the state, however, is still single detector system. About 70 percent by their estimation, and the difference is - I'm not going to try to explain the technology - the difference is multi-detector allows you to do certain applications such as pulmonary embolism application, clearly allows for better through per patient because it's faster and allows you better images. Clearly there are better images. There's less respiratory motion. And taking all of this into account, the recommendation of the standards would be as follows: That if one were to purchase or lease or whatever a PET/CT hybrid unit, if you had to have CON for the PET for this unit, and if you meet CT quality standards, there would not be a volume requirement if you use the unit to do CT scans only. Now, this unit costs literally twice as much money as simply buying the multi-detector CT. It's about 2.4 million and 1.2 million. No one is going to purchase this to do CT scanning. That's obvious. The rationale for this is certainly in the stage where we are

just now getting into PET and the machines will not be used as much as they would be in three or four years, when the PET patients are done at two, three, 4:00 in the afternoon, for example, and we talked about the availability of the isotone which limits how much PET scanning you can do, the same institutions instead of letting this multi-detector system lie dormant could use it for add-ons, emergencies, backlog, whatever during the rest of the day. And the other advantage would be is, not in the large institutions like U of M or Henry Ford because we have plenty of multi-detector systems, as does Ann Arbor and other places, but in middle size hospitals that may not have multi-detector systems, they only have single detector, common sense would dictate you put the patients on the best unit, unless you had to use two units. So for a number of reasons, the recommendation, my own recommendation and the department's recommendation would be, as I said, you don't need another CON for - another CON would not be subject to CT volume thresholds; however, any patients done on that unit, you cannot count in the future in an effort to obtain a CT CON, so there would be a consistent - you can't double dip. It wouldn't be consistency. That's the second change. The third change is the relocation of the acquisition, which is really more of a technical change. If you choose to move a unit within a ten mile area, you are not adding a unit, you are moving a unit or you are acquiring a unit already in that area. You would not have to get - you would not have to do a CON to initiate service. And the explanation for that is it would cut down on the people. This is something I personally don't feel as strongly about, to be honest with you, but the department and others feel a criticism of some the CON processes is it's slow and cumbersome. This would do away with it. This would not affect patient care, but would do that. The fourth item is the volume requirement of 7,500 CT units. Last Thursday evening at the Michigan Radiologists Society Board Of Trustees, we discussed that issue. It was the overwhelming feeling of the radiologists of which there were about 15 or 20 in the room, there would be no reason to change that standard. Admittedly, the radiologists were from the southern half of the state, the Tri-County area, Grand Rapids and Ann Arbor, but they felt that was a reasonable standard. Larry Horvath had specifically asked me about whether that standard needed to be changed after all these years. They felt no. That access, at least in that part - on our part - in the southern half of the state, this was not an issue. In the northern half of the state, the first item about allowing hospitals to be placed and to have a CT should appropriately help them with that access issue. So for both of these reasons my own recommendation to my fellow commissioners would be that there would no reason to change the volume standard, which admittedly is a big issue. Thank you.

MS. TURNER-BAILEY: Thank you. Are there any questions? Okay. I'm going to take the public comment on this issue at this time. Amy Barkholz. I'm going to ask anyone who wants to comment, to please do so before the Commission begins its discussion point 'cause then we're going to - we're moving on at that point, and at that point you're in the public comment at the end if you're not - if you'll come now - speak now or forever hold your piece.

MS. BARKHOLZ: Hi. Amy Barkholz, Michigan Health and Hospital Association. Very briefly, we completely support the proposed draft language from the department. There was testimony on July 11th on the CT standards. At that time we raised a few issues along with other people. The three issues I think that Dr. Sandler went over were making sure that rural hospitals with emergency facilities have access to fixed CT scanners and can replace and upgrade those. The other issue, the hybrid PET, you might as well use a CT that's part of it. It just make sense for efficiency. And also, the relocation and transfer of ownership of CT were all issues the MHA supported. We think that the department's proposed language addresses all these very effectively, and these issues were widely supported at the public hearing, so we hope that you'll move to adopt that language and put it forward to the legislature so these changes can finally be made. Thanks a lot.

MS. TURNER-BAILEY: Okay. Thank you. Are there any questions? Thank you. Kevin Burger.

MR. BURGER: Hi. My name's Kevin Burger. I'm director of PET/CT and assistant professor of radiology at Michigan State University, and I'm testifying in support of revising section 8 of the CT standards to allow the use of the advance CT scanning capabilities of hybrid PET/CT scanners. Many places like Michigan State University which have purchased hybrid PET/CT scanners have found that our PET/CT scanner by virtue of being the newest CT scanner in the department, also has the most advanced CT capabilities of any machine in our department. Certain CT scan techniques like CT angiography require more advance CT machines with multi-sliced capabilities that these new hybrid CT scanners often have. The proposed revisions would permit using the multi-slice CT capabilities of hybrid PET/CT scanners, but by Rule 4, that sub-section, not impact the CT review standard requirements. I think this compromise would allow us to improve patient care and quality of care provided by us, so I support revising the CT standards as proposed by the department. Thank you. Are there any questions? Patrick O'Donovan.

MR. O'DONOVAN: Thank you. I'm Patrick O'Donovan from Beaumont Hospital. I just had a question or wanted a clarification on the proposed standards. The definition of CT scanner now includes PET/CT hybrids if used only for CT procedures, which means it counts as one of your - one of your CT units; but then it says any - the other section says, any utilization that you use for CT aren't counted toward utilization for CT for another unit. I guess my question is, if you have two CT units and then you acquire the PET/CT hybrid, are you - do you then have three CT units? And - I'm not clear on how you would apply or what the math you would use to - if you wanted to expand to another CT unit. I don't know if you understand my question. It says if - if you have two CT units and you're just operating two CT units and you're doing your utilization, and let's say you have a PET/CT hybrid but you're not - let's say you're not using it for the other purpose of a CT only, but then you want to go to three units; when this department applies your utilization, they're going to say, well, how many CT procedures did you do, and you report everything on your two units, and they'd say, well how many CT units do you have, well, the answer is three because this defines it as - the definition includes the PET/CT as one of your units. You wouldn't meet the requirements to expand to a third unit. Am I missing something there?

DR. SANDLER: Sandler. This would be a technical change. My understanding that the spirit or the intent of the change, Patrick, would be as follows: To be consistent, you only have two units in terms of getting a third because you can't count the PET/CT -

MR. O'DONOVAN: Okay.

DR. SANDLER: - numbers. Therefore, if you wanted to get a third unit - you want to get another unit, I think the department would count that as your third unit, but you wouldn't be allowed to use any cases done on the PET/CT hybrid as part of utilization data to get an additional unit, so there would be a consistency there.

MR. O'DONOVAN: Okay. Well, that's my understanding of how it should work but I'm not sure that the definition section of the standards as written - that it says that, and I guess I'd just ask the department to -

DR. SANDLER: Okay. I will -

MR. O'DONOVAN: - to clarify that.

DR. SANDLER: - ask the department to follow up and make the language clearer. And, thank you.

MR. O'DONOVAN: Thank you.

MS. TURNER-BAILEY: Commissioner Goldman.

MR. GOLDMAN: I thought the answer to that was on the first page where it says a CT scanner is an X-ray CT scanning system including PET/CT scanner hybrids if used for CT only procedures. So in the example that you gave, you would have two CTs being used exclusively for CT. You would have a PET/CT hybrid used primarily for PET, but a little bit of CT overload. It wouldn't count as a CT scanner, and the CT scans done wouldn't count towards your overall numbers for acquiring a third machine.

MR. O'DONOVAN: Okay. Thank you.

MS. TURNER-BAILEY: So there's no need for a change is what - okay. Thank you.

DR. SANDLER: Thank you.

MR. O'DONOVAN: Thank you.

MS. TURNER-BAILEY: Is there a motion? Any further discussion? Oops. Sorry. One more card. Lody Zwarensteyn.

MR. ZWARRENSTEIN: Thank you. I'm Lody Zwarensteyn from the Alliance for Health, and I rise to support the standards as presented to you. In our area of west Michigan, we faced problems already with two of the three areas of change, the PET hybrid and the relocation already and how to approach those things that have been

problematic. We've had support from the department but have had to be creative. The other issue, that of the rural. Fortunately in the west Michigan area, the last of our critical access hospitals is going to be able to get a fixed CT based on its own volume without needing anything else, but nonetheless we think the standards are appropriate as presented. But I did want to make one other comment rather gratuitously. Many of the commissioners are new and I don't - or I wouldn't what to miss the opportunity to point out that the standards, although older, needing updating, did serve a very valuable purpose when adopted. CT, at the time it was new, was argued as to whether it even would be a viable technology, whether it's something that would be needed or not, a lot of concerns about who was going to get what. Standards were written to promote access. They made a generous allotment for rural areas by making mobile units very easily available, host sites could be set up. In fact, we got to a situation where just about every facility in the state that wanted a CT could get one and that access has helped us. Another thing the Commission did was to put in a financial limitation. They said for those scanners costing under $750,000, a lower threshold could apply to the - as opposed to those older. At that time I would remind the new commissioners or at least inform you, every manufacturer in just about all the hospital radiology departments were saying you won't find a CT scanner under 750,000 - the ticket price at that time was a million two to two million - but the week after the standards were adopted in the State of Michigan, all of a sudden scanners at 400, $500,000 became available. Everything the Commission was told was a lie. Things could be made available, industry can respond, does respond, and the standards did serve a very good purpose, and I mention this now because in the future as new technologies come under review, you may want to recall and reflect on what was done with CT because it did work for quite a while but now it's time to update it and we support the update.

MS. TURNER-BAILEY: Thank you. Any questions? Barbara Jackson.

MS. JACKSON: Good afternoon. I'm Barbara Jackson, EAM Regulatory Director, and we did support this modification of most of the discussions and the language today, particular - the emergency room, based on the practiced standards, but we also support the additional newer information in terms of the PET/CT hybrid, so thank you.

MS. TURNER-BAILEY: Thank you.

MS. JACKSON: Any questions.

MS. TURNER-BAILEY: Any questions? Okay. Any comments, discussions?

DR. SANDLER: I have one item. It's amazing everybody agreed on this, but there is still a problem in rural hospitals. I have been told antidotally by physicians, there still is a problem of access for CT such as in the Upper Peninsula. My suspicion is that older units are bad tupa (phonetic), and with this to be adopted, I think and I hope this would solve that problem.

MS. TURNER-BAILEY: Commissioner Breon.

MR. BREON: I guess the only question I have is I don't know if I have a conflict of interest here or not but we're' one of the organizations probably benefiting out of two out of three, I think, or maybe three out of four of these issues, and again I go back to our earlier discussion, I just want to state that we are one of the organizations involved in the PET/CT issue and also the transfer of ownership, but outside of that I certainly support this issue.

MS. TURNER-BAILEY: Thank you.

DR. SANDLER: By the same token, Henry Ford is in the process of getting a PET/CT hybrid as is University - as is others.

MR. STYKA: Well, they both indicated a potential conflict, but I don't think either one has reclused themselves; is that right?

DR. SANDLER: Correct.

MR. STYKA: So the chairman can ask for the body as to what you feel as far as whether or not anybody wants to make a motion as to whether they should recluse themselves or not?

MS. TURNER-BAILEY: Is there a motion as to whether or not -. Yes, Dr. Ajluni.

MR. AJLUNI: Mr. Ajluni. Motion that they be allowed in the discussion and vote.

MR. YOUNG: Support.

DR. SANDLER: Support.

MS. TURNER-BAILEY: Okay. It's been moved by Dr. Ajluni, supported by Commissioner Young and Commissioner Sandler that the two commissioners that just stated a conflict of interest be allowed to not only participate in the discussion but also vote on this issue. All in favor signify by saying aye - I'm sorry. Raise your hands. I have to move over to the raise your hand. Okay. All those opposed? It's passed unanimously, and at this point a motion will be in order with regards to the CT language.

MR. BREON: I would move to support.

MR. AJLUNI: Support.

MS. TURNER-BAILEY: Okay. It's been moved by Commissioner Breon, supported by Commissioner Ajluni that we adopt the CT language as presented and discussed. Any discussion? Yes, Brenda.

MS. ROGERS: Does that include moving it forward to public hearing?

MS. TURNER-BAILEY: And moving it forward to public hearing. Does he have to modify his motion to do that or can we just say that?

MS. ROGERS: You can waive it, as long as he's in agreement.

DR. SANDLER: There's a question from the audience that was yelled so loud from the back of the room that I could hear it here. The question is it had a public hearing but it had a public hearing before the standards, so doesn't it need another public hearing or does it?

MS. TURNER-BAILEY: Do we?

MS. ROGERS: We need - we still - that was part of our pilot project, so that's just a public hearing to get input and comment from the public, so now what the Commission is doing is taking its official proposed action and we are moving it forward for the regular public hearing.

MS. TURNER-BAILEY: Okay. So this is not adopting the standard? This is -

MS. ROGERS: Right.

MS. TURNER-BAILEY: - accepting the language -

MS. ROGERS: - the proposed -

MS. TURNER-BAILEY: - and moving it forward.

MS. ROGERS: - action, moving it forward to public hearing and then it will -

MR. BREON: That's what I meant.

MS. ROGERS: - be scheduled for final action -

DR. SANDLER: Final action would be -

MS. ROGERS: - in December -

DR. SANDLER: - December, at the December meeting.

MS. ROGERS: - at the December meeting.

DR. SANDLER: Yes.

MS. TURNER-BAILEY: So that - he said that's what his motion actually was, and it was supported by Dr. Ajluni. Any further discussion? All those in favor, please raise your hand. Opposed? Passed unanimously, and I just would like to take a moment to say that I think this process worked very well, and it was an example of how we are able to improve our process, and, Dr. Sandler, I would thank you, for -

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: - your time and effort.

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: MRT. Brenda Rogers.

MS. ROGERS: Again, this is Brenda Rogers. I'm just going to reiterate what I stated earlier. MRT, we are in the process of reviewing the public comment. The public hearing was held in July, and we will be moving forward with putting that language together.

MS. TURNER-BAILEY: And hearing that, I have two cards on MRT. I guess I would like to ask the two potential speakers, do you still want to speak today or would you like to wait until December when we actually have language to look at? Amy Barkholz.

MS. BARKHOLZ: I'll wait. I support developing language.

MS. TURNER-BAILEY: Thank you.

MR. MAITLAND: Are you all right back there, Amy? You are jumping around an awful lot.

MS. TURNER-BAILEY: And Robert Marquardt.

MR. MARQUARDT: I prefer to speak.

MS. TURNER-BAILEY: You can speak if you'd like to.

MR. MARQUARDT: Good afternoon. I'm Bob Marquardt, and I'm the president and CEO of Memorial Medical Center of West Michigan located in Ludington, Michigan. Ludington, Michigan is located in Mason County which has a population of about 28,000. I think that qualifies us as a rural area under any definition of rural. We provided testimony in July at the public hearing relative to our concerns regarding access or lack of access to radiation therapy by rural populations in Michigan. In my particular service area, patients must travel more than 60 miles one way to access care. It takes them minimally one hour one way or more in some of your infamous winter weather to access that care. We do have evidence supporting the somewhat antidotal comments of our surgical staff that we - our population in Mason County particularly has a higher mortality for cancer or due to cancer and also suffers a higher surgical morbidity as a result of not having access to radiation therapy. Several years ago I provided testimony to the CON Commission at that time regarding our concerns to access rural populations to radiation therapy. While the standards were modified at that time to improve access for rural populations, in our testimony we felt that the changes to the standards did not go far enough. I think I'm here to tell you that that problem still exists. People are still hurting, they're still dying as a result of not having access to this technology. At our public testimony we provided and proposed changes to the standards for MRT for rural areas. We would simply urge the department to circulate the proposed changes for consideration by the CON Commission and/or and appropriate (inaudible). Thank you.

MS. TURNER-BAILEY: Thank you. Are there any questions or comments? Surgical services, just a brief recap, please.

MS. ROGERS: Again, surgical services, we held the public hearing in July to receive the input from the public for proposed changes, and the department is currently reviewing those suggested changes, and we'll hopefully be presenting language at the December meeting, if everything goes well.

MS. TURNER-BAILEY: Thank you. UESWL Services.

MS. ROGERS: Again, we held a public hearing back in July. We are in the process of drafting that language. As I stated earlier, we are about 80 percent of the way through and hopefully be able to get that language to Commissioner Goldman, who is the liaison, by next week so we can start his review on that, and then we will be presenting that to the Commission at your December meeting.

MS. TURNER-BAILEY: Okay. Thank you. Don Pietruk

MR. PIETRUK: Hello. I'm Don Pietruk. I'm here on behalf of Henry Ford and Harper Hospital mobile lithotripsy. Obviously we've been working with the department on developing this new language and submitted our proposals at the public hearing process. We're kind of gratified to learn that they're very close, and what we were maybe hoping to ask the Commission, if it's possible, because the department is so close on this issue, if that language could pop up at the special meeting at the - when you do the hospital beds, and the reason for this is timing. UESWL is one of those services that's subject to comparative review, and if this - given the timing on this appearing in December, you won't do final approval till March, standards would go into effect in April, the earliest we could apply for a CON application is next June. And if we stretch out the approval process five months, we're looking at the end of 2004 before we could get approval on a unit, and then sometime after that be up and running. If we could shave even three, four months off that process because of the high demand and increasing number of scheduling problems we're facing that would greatly alleviate our situation. Thank you.

MS. TURNER-BAILEY: Okay. Thank you. Any questions? We can deal with that during the -

DR. SANDLER: There is a question.

MS. TURNER-BAILEY: Yeah, Commissioner Sandler.

DR. SANDLER: I apologize. I left the room for part of the time, nature called me. What specifically are you asking for? I missed the first half of your question.

MR. PIETRUK: Well, I didn't go into - I've come here a number of times. What we're specifically asking for - what our purpose - what our issue was, Henry Ford and Harper mobile was to ask for - we - to allow that the standard be changed to allow for expansion of an existing service because currently the number of units in the state is capped, so we can't get another unit. What we were looking for was relief for mobile providers that are doing very high volumes on their units, above 1,800 procedures annually, the ability to get another unit.

DR. SANDLER: Yeah, I actually was referring to the time period.

MR. PIETRUK: Oh, the timing. I'm sorry. The - specifically the timing - what we were asking is if this language could appear at the Commission's special meeting on bed need, but we know - we've heard the department's very, very close.

DR. SANDLER: Thank you.

MR. PIETRUK: That's what we're asking. Sorry. I misunderstood.

MS. TURNER-BAILEY: Any other questions? Bob Meeker.

MR. MEEKER: I'm Bob Meeker from Spectrum Health in Grand Rapids. I have a slightly different take on the timing of all of this. I'm - because of the nature of the issues, I'm a tad alarmed that there is proposed language that might even come to the next meeting. It seems to me that there are multiple issues here, and in many

cases they are conflicting issues, just as the mobile lithotripsy that Mr. Pietruk is advocating for is doing gang-busters worth of volume, they're doing it at the expense at least in West Michigan of an existing fixed scan - lithotriptor which has been very successful in the past, has been doing appropriate volume and is now in danger of not being able to meet volume requirements because the mobile, being as over-subscribed as he has contended, still is coming into an area that was being well-served beforehand. This is not necessarily to advocate for any one position, but rather to point out that I think that there are many and conflicting issues here, and for the department to bring forth language without the benefit of some, perhaps in this case a standard advisory committee, I think could be a mistake and would - could then have those discussions here in front of the Commission, perhaps maybe that's what you would prefer, but I would like to express concern at the speed of which this is going outside of public scrutiny.

MS. TURNER-BAILEY: Yes, Brenda.

MS. ROGERS: This is Brenda. Just as a remainder for the commissioners. In part - as part of this process, even just like today we brought the CT language forward. You have those options. You had the option today to either take proposed action to refer it onto to a standard advisory committee or other outside consultant, and you will have that same option when we bring these other three sets of standards forward, so just to keep that in mind, and that's a reminder for you.

DR. SANDLER: Okay. I'd like to make a comment to follow up Brenda Rogers. One of the real complaints that people had about the CON process is not our wonderful department or the Commission, it was the length of time to go from point A to point B, and that was a complaint I think the legislature tried to address in giving us more options. You just saw with CT, in the old days would have been six months to come to the conclusion we came to in about 20 minutes here, and by the same token I would recommend precisely the same thing be tried with lithotripsy. And, Bob, if we start talking about this and there's questions from the commissioners, there's a lack of consensus, a lack of information, the Commission as a group can vote to get either a standard advisory committee and/or experts to clarify the picture for us, but I'm real concerned about going to a system that might take six months when a half an hour at the next meeting may not - even the bed meeting or December 9th, that's up to the Commission, but a half an hour there, could take the place of six months; and again, I repeat, one of the real criticisms leveled at the CON process was the slowness. The end result may have been okay but the slowness is what got us into trouble, so to speak; therefore, I would strongly recommend that the department give us language, with Mr. Goldman as the consultant, and see if the commissioners can agree on it, like we did on CT, and if we can't, we have options.

MR. MEEKER: I understand that concern, and I would like to draw a distinction between the CT situation and the lithotripsy. I think in the case of CT, the issues were very clear-cut and there was no disagreement. My concern with bringing language is the concern of rushing too quickly to a conclusion that perhaps is not the best conclusion. Just as we saw our legislature rush to a piece of legislation that now even they admit has at least one provision that they would just as soon take out, I would rather not see the Commission commit the same action and therefore come back and say wait a minute, we really didn't intend that to happen in the case of lithotripsy, so all I'm doing is asking that there be some consideration of the fact that the issues A, are not clear-cut, and B, there is not consensus around the different issues in this case; whereas, in CT, I think that this new process worked very, very well. There was consensus, and, in fact, Dr. Sandler, I agreed on all four points.

MS. TURNER-BAILEY: And I actually don't think we're at a situation where we've gone down a road where we can't make sure that we're being deliberative in the process, so I think everybody's right. All right.

DR. SANDLER: There's still a question of the audience.

MR. PIETRUK: It's not a question so much as a response to Mr. Meeker if that's allowed?

MS. TURNER-BAILEY: Is it really - I mean, I guess I'm not really sure if that's necessary at this point.

MR. PIETRUK: I can wait until public comment, I guess, in the work plan.

MS. TURNER-BAILEY: You can always make your comments during the public comment section of the agenda.

MRI. I have a speaker, Ron Larsen, Hillsdale. He's actually on the agenda.

MR. GOLDMAN: Renee, let me just confirm that, MRI, my understanding is that the University of Michigan has a proposal for a MRI before the department at the present time, so I do have the potential for a conflict of interest on this agenda item?

MS. TURNER-BAILEY: Are you reclusing yourself from any vote on this issue?

MR. GOLDMAN: I don't know that we're going to be taking any vote today, are we? So I just want it to be known that we do have a request for an MRI unit, and I don't believe there is a vote. If there is any vote, I would remind people of my potential conflict.

MR. STYKA: The agenda only calls for a discussion and public comment today.

MR. GOLDMAN: That's my understanding but I just want it known.

DR. SANDLER: As well as the fact that it appears to be a rural piece, Ed, so I would -

MR. GOLDMAN: I understand.

MR. LARSON: Well, my name is Ron Larsen, and I'm from Hillsdale Community Health Center in Hillsdale, Michigan. We are the only hospital in the county, and it's a very rural area. I assume we'll still be under the rural definition, but I'm not sure. We along with some other small rural hospitals around the state, have experienced a negative impact on patient quality of care because we are unable to have a fixed MRI under the existing MRI standards. We have numbers close to what is required, but are unable to achieve the required numbers because many of our physicians will not use our mobile MRI for quality items. As a result, our rural community is disadvantaged. We need a fixed MRI, and after approaching the Michigan Health and Hospital Association for assistance, we've discovered that there are other small hospitals in rural communities, not a lot, but a few, in the exact same position. We believe the standards for a fixed MRI need to be reviewed and revised for us small rural hospitals. We're not asking that the standards be removed, only that minor modifications of rural hospitals be made, as have been done with some other standards. The changes we propose have been provided to you, and would only allow a few rural communities to have access to necessary care without opening up the standards unnecessarily. Thank you.

MS. TURNER-BAILEY: Thank you. Are there any questions or comments for Mr. Larsen?

DR. SANDLER: Do you wish to have us respond to this piece of paper on his four recommendations? Is this the appropriate time for that?

MS. TURNER-BAILEY: Did you have a comment on this?

DR. SANDLER: Yes.

MS. TURNER-BAILEY: This would be the time.

DR. SANDLER: I have several comments. I probably need to know more about the issue, but my visceral feeling is that there is a very legitimate need and concern here.

MR. LARSEN: Thank you.

DR. SANDLER: So I'll put you at ease on that.

MR. LARSEN: Okay.

DR. SANDLER: That would be item number three here. I have some problem with two and four, which I wish to address. Two says the process of nonprofit inpatient facility, meaning a hospital obviously.

MR. LARSEN: Yes.

DR. SANDLER: And being the Chair of the Board of the Michigan State Medical Society, my response to that is, this would be something a little different because these are relatively small rural hospitals and the competition between an outpatient facility and the hospital can be fairly deadly in terms of the economic viability of either one, so I certainly can understand that in this one case. I would ask my commissioners that this should not be considered a precedent for other changes in MRI or other standards, however. So, again, no problem. Number four has to do with the Board of Trustees doing a due diligence investigation. I'll tell you what, you seem like a very intelligent fellow, Mr. Larsen. We trust that you - I personally trust that you and the trustees at Hillsdale don't have to assure us of the economic viability of your unit otherwise you wouldn't be doing it presumably.

MR. LARSEN: That's correct.

DR. SANDLER: And, therefore, I don't think the CON Commission should ask that of either you and your hospital or the other - or any other hospital. If we feel that 4,000 is appropriate - I'm not certain it is yet, but it could well be, that should - that in itself should be the due diligence, and I actually think we should not look at the fourth item here. I personally think that bullet should be removed.

MR. LARSEN: Thank you.

DR. SANDLER: You're welcome.

MS. TURNER-BAILEY: Any other questions or - any other questions or comments?

MR. LARSEN: Thank you.

DR. SANDLER: Excuse me. I got this when you - it's been pointed out to me by a colleague here, and I kind of grimaced when you said there's something wrong with the mobile MRI in your area. I'm a little confused why the mobile MRI doesn't have acceptable quality reasons because generally they do?

MR. LARSEN: What I said in there is that some of our physicians, many of your physicians are concerned about the quality of the mobile MRI and would rather schedule their patients elsewhere, to a fixed unit, and the reason is that the mobile unit is probably several generations old -

DR. SANDLER: Okay.

MR. LARSEN: - and has traveled around the county - the counties in the back of a semi-tractor truck for many years, and so some of our physicians have a very deep concern about the quality of the image that we -

DR. SANDLER: Yes. I glad you explained that because there's nothing inherently wrong in mobile MRI that you wouldn't anticipate the same quality as in fixed MRI.

MR. LARSEN: Not in and of itself, no, sir.

DR. SANDLER: Okay. Fine.

MR. LARSON: But what we're dealing with is an excess issue where -

DR. SANDLER: Well, plus -

MR. LARSEN: - you know -

DR. SANDLER: Well, it's an older unit. That may be an issue, just like the older CT unit.

MR. LARSEN: Yes.

MS. TURNER-BAILEY: Thank you.

MR. LARSEN: Thank you.

MS. TURNER-BAILEY: There's several other comments with regards to MRI. Amy Barkholz.

MS. BARKHOLZ: Hi. I'm Amy Barkholz, MHA. What Ron said, and what a few other hospitals are coming to say today - I know you've gotten some communications in writing too about this proposal - we would echo. The MHA supports the proposed changes to the MRI standards to provide additional access to fixed MRI machines. The proposal is narrow. It's targeted to address the needs of patients in counties not currently served by fixed MRI machines. At present it will allow seven additional fixed MRI machines in the state. Some of the materials that are coming around include a map that's in color and it kind of will give you a picture of where the MRIs are now and where the folks that might be impacted by this language would be located, so I think it's helpful to visualize it. The proposal was prompted by concerns from smaller rural hospitals that the current MRI standards aren't sufficient to meet patient needs in their communities, and, as you've heard, the mobile service providers are unable to offer them sufficient time to meet the demand. In many instances, for instance, we're talking about War Memorial up in Sault Saint Marie, Mercy Monroe. These folks are operating fairly close to the volume level that you could currently use to get a fixed MRI, but they are maxed out in the amount of time the mobile service provider will give them, so they have some unique situations, and in the past we have done car bouts (phonetic) for rural areas or areas that are under serving. We think this is consistent with that. I think what we're asking today since this is the first time that you've seen this proposal and heard about this issue, is to keep the issue alive and keep it moving forward. We had success, I thought, with the idea that - I think you suggested, Ms. Bailey, to sign a commission liaison or a person to help forward an issue along, gather some comments, gather some proposed language. It would be my hope if the Commission would agree today to maybe assign a person like that who could get some more input, perhaps we could work with the department to take this language and put it into a proposed format that other folks could comment on, and I think that's what we would hope would happen today. Thanks a lot.

MS. TURNER-BAILEY: Thank you. Are there any questions? Comments? Okay. Thank you.

MS. BARKHOLZ: Oh. One quick question - or a quick comment. Dr. Sandler, you commented on two items in the proposal. The one dealt with the due-diligence issue, the other dealt with the nonprofit facility. Two quick responses. One, a nonprofit facility does not necessarily have to be a hospital, but our belief is if we are making the argument that there is an access problem, we want to make sure that the unit is placed in a facility where the most people can come, and clearly a nonprofit facility must take all comers, Medicaid, et cetera, so we think it's best to house that if we're making a rural or access exception. The other issue that talks about Board of Trustees doing due diligence, it may in fact be the case that that's a superfluous bullet point. That came about in the MHA's discussions to make sure that we were able to effectively counter arguments that a lower volume level may not be economically viable and we wanted to assure folks that we are only going to be putting economically viable units in. Thanks.

MS. TURNER-BAILEY: Thank you.

DR. SANDLER: Let me respond. I have no problem with this particular standard if it's adopted by the Commission at some point being limited to a nonprofit facility, I want to make that quite clear. I have a very big problem with that being a precedent establishing for all standards and all things that has to be - that nothing else has that right now, but I do have a problem because this is a unique circumstance of access to rural areas and I have no problem with it. Thank you.

MS. TURNER-BAILEY: Thank you. David Kreger.

MR. KREGER: Hi. My name's Dave Kreger. I'm vice president for operations of Mercy Memorial Hospital of Monroe, and I appreciate very much the opportunity to offer a few brief comments in support of a proposal to amend the current MRI standards.

Mercy Memorial Hospital is the only inpatient facility in Monroe County and the only location offering MRI services. We've had an arrangement for a mobile service since July of 1991, and only within the last year have we been able to achieve a commitment of Monday through Friday availability, although our mobile provider attempts to be accommodating since all of these typically fall on Mondays, there are some weeks when we only get four days of service instead of five. Nonetheless the unit went on site to operate 16 hours a day and current utilization is approximately 5,100 adjusted procedures annually. Still, at present, demand exceeds capacity.

And in an effort to obtain timely information for diagnostic and treatment decisions, members of our medical staff regularly refer patients to Downriver Detroit, Ann Arbor or most commonly to Toledo. Ohio is a non-CON state, as you all well know I'm sure, and there are currently 12 fixed site MRIs in the Toledo area. From recent interactions with the consultant familiar with the northwest Ohio Diagnostic imaging market, there's an estimated 20 to 24,000 adjusted procedures per year from Monroe County residents who travel to Ohio for testing. And I don't know if Mr. Steiger is still here, but assuming that Blue Cross agreements work the same way they do with other services, Blue Cross may well be paying a premium between 20 and 30 percent more for procedures performed in Ohio than they are in Michigan on behalf of Michigan subscribers. Without modifying the MRI standards, it will certainly be difficult for us to achieve the volume threshold necessary for a fixed site unit. It's taken over a decade to obtain 5 day per week service, and although we've been actively supporting our provider's effort to obtain the volume commitments from physicians necessary for another mobile unit, there still isn't any kind of a guarantee that the service would be made available to us. We appreciate your thoughtful consideration of this proposal. We believe its endorsement will be in the best interest of the residents of Monroe County for improving access through enhancing the quality of information available for their treatment and diagnosis, and through reducing costs to their insurers and employers. Thanks for your attention.

MS. TURNER-BAILEY: Thank you. Any questions, comments? Thank you. I also have a note here from Ben Bobkin from Senator Cameron Brown's office who says he doesn't want to speak but wants to let us know that they support the revision to these standards brought to the Commission by the Hillsdale Community Health Center. That's it. New Medical Technology. Brenda.

MS. ROGERS: No changes to report.

MS. TURNER-BAILEY: Thank you. Commission Work Plan. At this time I will call Dr. Eric Bates.

MR. HORVATH: I was just going to do update before Dr. Bates actually speaks.

MS. TURNER-BAILEY: You can make us wait -

MR. HORVATH: Just on the PCI standards that just became effective August 4th. The department has received two applications for that provision. I just wanted to give the Commission an update on that. We also are continuing to work with the University of Michigan and the - well, the Data Network, to try and get that arrangement installed so they can actually monitor the PCI and actually be reporting back to the department on that, so we continue to work out those contract obligations with the university.

Dr. Bates called and talked to the department because he was interested and concerned during his work during the Ad Hoc Committee about some provisions that were in the cardiac cath standards. As you all are aware, under 619 - PA 619, the department is now required to take enforcement action on these provisions. In the past we usually took enforcement actions during the review of a subsequent application by the entity or through an allegation. Now we're required to do that, and the department is taking the steps necessary to look at all of the provisions in the standards and make sure that those entities that are approved under those standards are actually meeting those requirements. There was concern raised during our ad hoc committee about some of the provisions that Dr. Bates is going to talk about today, so we invited Dr. Bates to come forward and talk to the Commission about his concerns and some of the physicians' concerns about some of the requirements in the cardiac cath standards.

MS. TURNER-BAILEY: Okay. Thank you. Dr. Bates.

DR. BATES: Thank you very much for this opportunity. I stand before you as the president of the American College of Cardiology, Michigan Chapter, which represents the 600 board certified physicians in the state who furnish cardiovascular services. What Larry is talking about is language in Section 11, and I've summarized my argument for you on this handout, which I'll go through as quickly as possible. To paraphrase, Section 11, paragraph four, "The law states the credentials physicians shall perform as the primary operator of minimum 100 adult diagnostic catheterization procedures per year." And the next paragraph, number 5, "Credentialed physicians shall perform as a primary operator a minimum of 75 adult therapeutic cardiac catheterization procedures per year," which are balloon and stet procedures that you might be familiar with. The regulation goes on to suggest that it's mandatory for hospitals to report annually to the department the name of the physician and number of procedures performed by each physician. This law has been in placed since 1994, but

only last year was Stan asked to try to meet the letter of this law and perform an audit on reporting the number of procedures by a physician, and he got stuck with a number of very difficult problems making definitions of the proper procedures and figuring out a methodology to accurately tabulate these numbers and procedures, and the first effort was relatively unsuccessful. And he's trying again this year, although I suspect he's having similar problems, so what I am asking you today is for you to consider changing this language and actually taking away these volume criteria to make Stan's job a lot easier.

MR. NASH: Amen.

DR. BATES: Historically, again, these regulations were placed in the documents in 1994 and they were pulled out of context from guidelines written by the American College of Cardiology, which were meant to serve as goals, not regulations. In 1991, the guidelines for cardiac catheterization suggested 150 diagnostic procedures should be the goal of every physician performing these procedures. There's no data to support such a number as far as guaranteeing quality and that number has been deleted from all the subsequent guideline revisions, so that point's pretty easy. There's no proof that a guideline or regulation stating a volume for diagnostic procedures has anything to do with guaranteeing quality. A little trickier are the therapeutic or angioplasty procedure guidelines that state one has to do 75 procedures a year. There does appear to be a mild relationship between volume and outcome but it's very complicated because you can be a low volume operator and a high volume center with 15 years of experience very carefully and purposely (phonetic) select your patients, do excellent procedures and have better outcomes and practice better medicine then somebody doing 200 procedures who selects perhaps two many patients to undergo the procedure who may not have as good a procedure outcome; and anybody that's familiar with clinical medicine knows volume is no good surrogate for quality. There are some high volume folks who are not practicing the same quality of medicine as the low volume people. So the reason I stand before you is because there's a major risk to members of my organization that their volumes will ultimately be published in the newspaper and that somebody will be judged as being inferior as a cardiologist because they performed 75 or 100 procedures compared to somebody who's performing 200 procedures, and that's threatening to some of our members, and I think it's a poor representation of how to judge people in the public arena. The field has moved on dramatically. Volume criteria are no longer considered adequate surrogates for quality. Now the field looks at data monitoring of outcomes and continuous quality improvement initiatives, and most large organizations are now moving toward that end. The American College of Cardiology and the Society for cardiac angiography innovations, which is our subgroup - our subspecialty society, encourage quality processes as a means for improving the value and quality in vascular care and discourage strongly state reliance on volume criteria to regulate catheterization laboratories. We have a number of guidelines including guidelines on cardiac catheterization that were revised two years ago, and guidelines on coronary angioplasty that are being released this year to serve as quality recommendations for practitioners. We have a national data registry to which 410 hospitals, about 25 percent of the laboratories in the country subscribe that offers quarterly and annual reports that provide safety and ethicacy measurements and confidential and validating - and valid benchmarking against other hospitals regarding outcomes and processes of care. And in a couple of weeks we're releasing something called a CQI toolkit for cardiac catheterization. This organization has very strongly come down promoting quality as one of the true core values of our organization. And there's one more comment, the Leapfrog Group, as many of you know, is a Coalition of 135 public and private organizations that provide health care benefits. This group is moving away from volume measurements to evaluate hospitals and towards performance measurements. And last year they are now requiring hospitals participating in NCDR to report risk-adjustment mortality rates rather than volume criteria. And next year when NCDR has risk-adjusted morbidity rates, they're going to do away with volume reporting. So clearly the purchasers and the large groups involved with quality are moving forward and away from volume criteria. So I would make the following proposal on behalf of my Chapter, and that is that mandatory reporting of cardiac catheterization procedure volumes be replaced by mandatory participation in the American College of Cardiology, the National Cardiovascular Data Registry, and that all 65 hospitals in this state performing invasive cardiology procedures be required to participate in this registry. To finish, there's several benefits, I think, that would be good for all the parties involved, and they would result from changing these requirements. The citizens would experience improvement in clinical outcomes that result from CTY . Anybody in business or medicine associated with these processes know that they result in better outcomes. The department would not be burdened by collecting data because data would be submitted annually on standardized report forms that would fulfill all the monitoring requirements that Stan's responsible for. The purchasers and payers would know that every cath lab in the state is engaged in a standardized outcome to use in comparing hospitals as they make health care decisions. The hospitals have a tricky role in this. They would be in charge of credentialing, which I think is probably the best place for that responsibility to lie; also be

motivated to improve outcomes because of competition there in the bottom quarter on the performance standard. The hospitals would bear some costs. There's about $20,000 to buy the software and four or $5,000 a year to belong to the program, but this could be considered the cost of doing business if they want to perform invasive cardiology procedures. The CQI program should already exist in the hospitals having cath labs. They should already have people involved with collecting data or the nurses or techs in the cath lab could easily be trained to fill out the forms, and they could use the data for credentialing requirements which already exist to certify their hospitals. Importantly, the cath lab directors would again become responsible for supervising improving quality rather than having to respond to a regulator or a payer or purchaser's directives. We strongly believe that the physicians need to take responsibility and control of quality issues as part of our professionalism and our responsibility to the patients and payers and purchasers, and this would bring the control back to the level of the cath lab director. The cardiologists, I think, would have to buy into this increased regulatory environment and this potential for public reporting of outcomes. They would not have their individual procedure volumes recorded or discoverable. And, finally, the ACC and the NCDR would advance its quality mission to the Michigan Certificate of Need Commission, and the Michigan Chapter would establish a new national benchmark for CQI participation in cardiac catheterization laboratories because there is no other state in the union that currently requires this degree of public recording. I would be glad to answer any questions.

MS. TURNER-BAILEY: Thank you. Any questions? Yes, Commissioner Hagenow.

MS. HAGENOW: I need a microphone. Ms. Hagenow from - well, actually it doesn't matter. I'm a commissioner. I don't have to say where I'm from. I've gotten sensitized to where I'm from. I very much like what you say, but I also found that as you go down this path of requiring quality, I immediately run into the coding makes a difference on the risk adjustment, and so as you see a statistic then go to how well, how was it coded and was it the physician that didn't document everything or was it the coders that didn't understand all of the rules, so it becomes in question right away, you know, and so - so that's my first concern is that I think the reason all of the states haven't done it yet is because they run up against this and don't know how to deal with the argument around definition, even though the definition may be pretty clear, it's still in operationalizing it is still not that clear. Secondly, to put the credentialing then onto the hospital, so the hospital says this is the data and you're no longer going to be credentialed because you don't meet the criteria. They then become in a litiginous situation, and I've experienced that in my career, and it's not an easy role because of the non-absoluteness of - of the data and becomes just a big adversarial battle with a lot of folks spending A lot of money and not necessarily achieving what you're talking about in terms of - so I've come to the position of let's have the data and then have continuous process improvement, but not necessarily this comparative data with an absolute line. I just don't think we're that refined yet, and I'd just like to hear your comments on what I've said.

DR. BATES: My major goal is to remove the volume criteria so that individual physicians don't get called out unfairly and the quality of their care does not get unfairly interpreted. We can stop right there if you're all in agreement. My thought was, though, because quality is important and because there's increasing a need to demonstrate the payers and purchasers and patients are getting what they expect, and because we as a profession are now trying to embrace the quality initiative, but some of this is quite reasonable. The NCDR has been a 15-year evolution because of all these coding and definition problems that you're aware of. And the science has progressed to the point where they're much more sophisticated and they now have a national agreement on definitions, and, again, they have 25 percent of the cath labs enrolled, and, in fact, they're making a little bit of profit of it. This is not a money losing venture. The coding problem is always a problem, but if we have one standardized data sheet, you know, you do a cath, you do a coronary angiogram, you do an angioplasty, you do a stent, there's 140 elements approximately, you fill out the boxes and that's what gets recorded. It doesn't have to be what comes to Lansing, that's what comes back to the cath lab director, so it has to become standardized. There's several regional programs including one in the State of Michigan that has 17 hospitals out of 30 involved. And there is no perfect system, you're right. And the major goal, I think, professionally and from the part of everyone involved really is the CQI process. The data aren't as important as engaging in the process. That obviously is what makes things go. As far as credentialing, I think there's a bigger - bigger problem now. That's always going to be a legal issue. Right now one could argue that if the diagnostician is not doing 100 cases, they shouldn't be given hospital privileges, if Stan goes forward and you enforce the law as it's written, so perhaps my suggestion to take out the volume would actually decrease the potential for legal issues because if one does the numbers, probably 50 percent of the people doing procedures in cardiology are below these thresholds, and that's nationally for angioplasty.

MR. GOLDMAN: I have a question. What differentiates this from - first of all, I'm not a big fan of volume numbers either, but the fact of the matter is that's the life we live in. If you see all the criteria for CT and MR and everything else, they're all based on numbers. What differentiates what you're talking about and why shouldn't you be held to those same kind of standards, because I don't if empirically it's been proven that 6,000 CTs is the magic number to have a machine, but that is what we deal with?

MR. BATES: I think that's a fair question and I'm not expert enough to give you a global explanation. All I can tell you is I think the cardiology profession probably is ahead of a lot of groups in pursuing this progression from volumes to CQI and data registering. Again, 17 of the 30 cath labs in the state are participating in Blue Cross-sponsored registered angioplasty. Twenty-three, I think, of the thirty open-heart surgery programs are participating in the thoracic surgery registry voluntarily. So, actually, when you go to these national meetings, Michigan is leading the way in quality improvement initiatives in cardiology, and I think the volume criteria represents some benchmark where we were ten years ago. I think we've gone beyond that with a number of efforts around the country and in the state to go to a higher level where we collect outcomes and we risk adjust them and we use them for CQI purposes. And the challenge from my point is not that process, it's how we use them to interface with the regulators and the purchasers and the payers, and public disclosure of those data which in some ways undercuts the CQI process.

MS. TURNER-BAILEY: Stan.

MR. NASH: My name is Stan Nash, and I work for the CON program. Let me clarify.

MR. STYKA: Stan, take the podium.

MR. NASH: Let me clarify your question for you. One is it's an apple and oranges issue. They're two totally different issues. When we look at utilization standards for CT or MRI or MRT, those are machine utilization standards unrelated to quality issues. What Dr. Bates is concerned about is a totally different issue, and that is trying to relate numerical values with a quality of care issue, and none - none of the other standards do that; in other words, they don't tell you that if you're doing 7,500 CT scans a year that they're really good scans and that they're really clear and that they're read correctly. They don't tell you that. All it tells is that you use the machine X amount of time. So you need to be very careful on how you compare -.

UNIDENTIFIED SPEAKER: (Inaudible)

MR. NASH: That's correct. And what Dr. Bates is concerned about is a quality of care issue in an attempt to improve the quality of care. I mean, clearly there are some standards which do relate to volume, and, I believe, correct me if I'm wrong, but I think open heart surgery's one of them, but where there has been an association between the number of open-heart surgeries you do and the quality - quote, quality of care, but you need to listen to what he has to say on the other stuff, on the cardiac cath.

DR. BATES: Well, the only thing is -

MR. GOLDMAN: I listen to cardiologists all the time so...

DR. BATES: Angioplasty and bypass graft surgery have been under the regulatory microscope more than almost any other aspect of medicine, and, again, it's just a response for a longer period of time on how to meet those increasing demands for quality.

MS. TURNER-BAILEY: Dr. Ajluni.

MR. AJLUNI: Dr. Bates, I listened to you carefully when you talked about volume and how it doesn't necessarily translate to quality, but are you saying that there is not a volume level below which you would not be comfortable with; in other words, if a cardiologist were doing 10 caths a year, that would still be acceptable in your mind?

DR. BATES: If I were a cath lab or a hospital administrator, I wouldn't allow that person to practice in our laboratory.

MR. AJLUNI: So we're just shifting the onus onto the hospitals and the cardiology programs.

MR. BATES: Well, I think the onus should always be on the cath lab director. That's the person who's best able to understand the guidelines and the best practice of medicine and the safest -

MR. AJLUNI: But that -

MR. BATES: - performance of the procedures.

MR. AJLUNI: Excuse me, but that dissipates as quality is - quality measure, whatever you want to call it, to 60 or 70 people at all the cath labs in the whole State of Michigan, does it not? And then the quality becomes only as good and as stringent as the cath director is; is that fair?

DR. BATES: I'm not quite sure - are you arguing in favor of maintaining the...

MR. AJLUNI: I see your point with -

DR. BATES: - the volume criteria?

MR. AJLUNI: - the volume, but I can envision a situation where volume was extremely low -

DR. BATES: Yeah.

MR. AJLUNI: - the cardiac director for whatever political, economic, whatever reasons is asleep at the switch and you have a practitioner doing very low numbers that, probably, as you said, shouldn't be doing them in those extremely low numbers.

DR. BATES: It all depends on the outcomes. If you subscribe participating in a registry where those 10 or 15 procedures are counted and the outcomes are measured, if that physician has no complications in 15 procedures, then it's hard to be critical; it's not what I would recommend as practice, but the concept is there probably are a couple of folks who are not performing procedures up to standards, and the question is how to find those folks and how to either change their practice or remove their privileges. And by stating that somebody has to do 100 cardiac catheterizations or 75 angioplasties doesn't get close to reaching the more crucial issue, and that is finding those folks who are not performing up to standard and having a means of keeping them from doing those procedures on patients.

MR. AJLUNI: Further, as you pointed out, that volume doesn't necessarily translate to quality, and there - I think you said there are no studies that would support that. Did I understand you correctly?

DR. BATES: There's no studies of diagnostic cardiac catheterization. There are a number of studies with angioplasty, as Stan said, with (inaudible), suggesting a small relationship, but you're talking about less than one percent difference in low volume and high volume operators. You get statistical values and show an academic relationship that somebody's taking care of 75 or 100 patients a year or a hospital doing 300 or 400, it's very hard to show that relationship.

MR. AJLUNI: Is there hard data to support what you say with regard to data bank registry and quality improvement issues even though that one would anticipate that that would improve quality; is there data out there to demonstrate that?

DR. BATES: Again, I'm not an expert in quality but my understanding is that the CQI process has been embraced by business and now by hospitals as a very effective means of improving process and improving outcomes in quality. And I'm not a scientist or an artist in that field, but that's what I understand, that people have embraced it and they're promoting it in the medical field.

MR. AJLUNI: Thank you.

DR. BATES: Somebody here works for GM, the auto companies - I think we stole it from the auto companies or from GM; right.

MS. TURNER-BAILEY: I'm from Ford but...

DR. BATES: There was a GM person on the board.

MS. TURNER-BAILEY: And I still - I actually still do buy do into the - too, on a broad sense, the volume as a proxy for quality, although I do agree and understand that there is certain movement, especially with regards to Leapfrog and other areas where we're moving to outcome, but there's also a relationship to public reporting there, and I think - so, you know, that piece that says we have to say we're not going to public report, I have trouble with that. That's sort of a different hat.

DR. BATES: Well, if you adopt the NCDR strategy as a replacement for volume, you would have data from all 65 cath labs, depending on how the negotiations go. I don't know whether it's be ten elements or 140 elements on this data form for each procedure form dumped on Stan's desk, and I believe it is available by the Freedom of Information Act. So it's, in fact, actually quite radical in concept because it would open up the opportunity for public reporting. It would allow Ford and other folks to see what they're paying for.

MS. TURNER-BAILEY: Which is something we always want to know. The question I do have, and I think you're answered it. You said there's 65 labs. And how many are already participating in the registry?

DR. BATES: There's a therapeutic - there's an angioplasty registry, 70 out of 30 hospitals. 35 hospitals do diagnostic procedures, and no therapeutic or interventional procedures. They don't do angioplasty or surgery. So this would involve both the diagnostic - the 65 diagnostic laboratories and the 30 plus or minus one - I don't know if we have the final count - therapeutic laboratories.

MS. TURNER-BAILEY: Dr. Ajluni, did you have a question?

MR. AJLUNI: Just one follow-up. I thought that the registry was confidential, now I'm hearing you say it's open to -

DR. BATES: The registry is confidential by individual.

MR. AJLUNI: Okay.

DR. BATES: It is confidential by the hospital, but if one wanted to make that the tool by which the hospitals were required to report data to the state, I doubt if anybody would want to do something different because it would be redundant. The State of Massachusetts has mandated that all eleven angioplasty laboratories participate in this ACC registry, and that data by law is reported to their State Department of Community Health. That's the only state where you have mandatory recording of NCDR data. Other states are considering it, again, as a substitute for volume requirements, which other states are starting to look at, as we did 10 years ago.

MS. TURNER-BAILEY: Statistical - I'm sorry. This is Commissioner Turner-Bailey. Just to go back to the beginning, you're saying that you think we should get rid of the volume criteria and replace that with a requirement for participating in the registry, and there was something else, there was a second piece that you said.

DR. BATES: That's pretty much it.

MS. TURNER-BAILEY: Okay.

DR. BATES: My first goal is to remove from the law the requirement that individual practitioner procedure volumes are reported to the State and discoverable by those who want to discover them. I think that's an unfair way to measure quality, and it would create an unfair evaluation of physician performance. If you accept that, that's great. If you want to replace it, which I would assume would be of more interest to members of the Commission and the community, I would offer what we think is a far more sophisticated substitute for guaranteeing quality, and that is participation in this professionally-sponsored data registry, which would allow one report to be generated for all the hospitals which would allow data to be used by the cath lab director to work with individuals within their laboratory to improve performance for individuals, but which would not be

discoverable on an individual basis, but the institutional reports could easily be required to be submitted to Lansing, and one would have the ability to evaluate the hospitals by outcomes regarding diagnostic catheterization, therapeutic catheterization procedures.

MS. TURNER-BAILEY: Dr. Sandler.

DR. SANDLER: I have several questions. Is the Leapfrog, which is a very well-represented group, going to that in the next year? You seem to indicate it's moving there but when you say -

DR. BATES: Yes. The Leapfrog Group this last year substituted outcomes in the form of risk-adjusted mortality for volume criteria in hospitals that participated in NCDR. Next year, NCDR in April will have version three out. It will include risk-adjusted complication rates, and my understanding is the contract - or the agreement - verbal agreement they have with our organization was that next year they will accept NCDR data and they will not look for volume criteria. They replaced their volume reporting with these risk-adjusted outcomes from the NCDR.

DR. SANDLER: Okay. Thank you. One other question, I apologize, I didn't get. How many labs are there that do only diagnostic cardiac cath and how many labs do both?

DR. BATES: We're close here. We haven't quite got the final tally. We believe that there are 30 laboratories doing therapeutic or angioplasty procedures and bypass graft surgery. There's an additional 35 hospitals doing diagnostic only, a total of about 65 hospitals in our state out of 140 hospitals, total -

MR. NASH: Somewhere in there.

DR. BATES: - 150?

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: Are there any other questions? Dr. Young?

DR. YOUNG: Is complete volume elimination important or is the number of procedures, the 100 versus 75, for your organization, your cardiologists?

DR. BATES: What we don't want is somebody's name in the Detroit Free Press with the number of caths they performed in the last year, no risk adjustment, no explanation of how those numbers were arrived at. They might have been sick for six months. They might be slowing down their practice. They might have 15 years experience. Right now a single number, we think, has the potential to embarrass a large number of practitioners and have absolutely no reflection on the quality of care they provide.

DR. SANDLER: If there's nothing else, I'd like to have a motion, if there's no further discussion.

MS. TURNER-BAILEY: Are there any other questions? Dr. Sandler.

DR. SANDLER: I'd like to make a motion that the Commission basically do what Dr. Bates has proposed, that there no longer will be mandatory reporting of cardiac catheterizations by procedure volumes, and this be replaced by mandatory participation in the NCDR by the 65 cardiac - approximately - well, I'll say all of the cardiac cath labs in Michigan so in case five more show up, it's still valid. That is my motion. Is there a second?

MS. TURNER-BAILEY: I haven't heard a second and not hearing a second, the motion - the motion dies. I think if - yes, Larry.

MR. HORWITZ: I turned a card in for comment on this item.

MS. TURNER-BAILEY: I want to make sure there's no more questions for Dr. Bates. Are there any other questions or comments? Okay. Thank you very much.

MR. HORWITZ: I want to express - Larry Horwitz, The Economic Alliance, I want to express hesitation, reservations and concerns about this; when Dr. Bates and some of the rest of us were very busy before the prior

- previous constituted Commission, and we were going to allow angioplast - I said - am I correct, allowing open-heart surgery to be done at - primary angioplasty.

DR. SANDLER: No, no. It's therapeutic angioplasty.

UNIDENTIFIED SPEAKER: Therapeutic angioplasty with cardiac surgery -

MR. HORWITZ: Right.

DR. SANDLER: On patients with immediate -

MR. HORWITZ: No, I understand. They had an immediate risk, and we eliminated the requirement. It was one of the very first things that the new Commission voted on for open heart surgery backup; right? So we set up a system where you could have what are in effect low volume angioplasty programs being allowed to do - diagnostic cardiac cath labs now being able to do therapeutic caths, otherwise called angioplasties, in low volume circumstances because of the offsetting consideration that the patient presents with an immediate critical situation. This was a matter of great and deep concern to purchasers and consumer groups that we represent and others. And after some tortuous dialogue and negotiations, whether the numbers were 36 or 48 or something else, it was worked out. And one of the key elements that was assuring to people about this is that there would be a means of monitoring volume, at that time the only proxy for quality we had. If - and that was the understanding, and it's only taken effect a few months ago. We don't have any data or anything else. If we proceed now to wipe that volume number - our reporting number out, that's a serious denergration of the understanding we had with people - a lot of people having great concern about having primary angioplasty done at a low volume facility without open-heart surgery backup. The proposal - and one of the concerns I'll have it come up later is I didn't know what this proposal was until I just heard Dr. Bates talk about it. To the extent that you are saying you're going to replace that with a different requirement, I don't think CON can do that. If I have a Certificate of Need from the past, and I received the Certificate of Need based on certain requirements, you cannot come by and later change the CON standards and have this new thing called participating in NCDR be now a binding requirement on the previously recognized CON. Ron's shaking his head. So you can't - you cannot - CON does not have the power to establish new criteria for operating - for having a CON and operating a program retroactively. So if you wipe out the volume number, and a particular cardiac cath lab says, I'm sorry, we're not interested in participating in the NCDR program, possibly we agree with Ms. Hagenow that you didn't risk-adjust it right, and everyone's got a different view of risk-adjustment, then you are taking a significant step backwards. Number two, one of the things that people were concerned about was not to be leaving this to the particular judgment of the cardiac cath lab. Not having a doctor - in California, they don't have any of these things. There are doctors in hospitals that are being - brought to the attention of the media in which very specialized heart procedures are done, incredibly low volumes per facility, not to mention very low volumes by doctor. And consumers say, from the perspective we have, have a right to be able to get information to determine what cardiologist they're going to use. And every data that we've ever said we've ever seen says that volume by hospital is important, but it typically tends to be that volume by operator is even somewhat more important. Where would we go to get that data? A lot of cardiologists who do these kinds of things practice at multiple hospitals, and it's finally worked out with great pain to figure out how to add it all up to figure out what the total volume was because there's always a concern that if you're measured and evaluated, you will be measured and evaluated wrongly.

My children are worried about that when they get grades in school. Everyone of us is concerned about not being evaluated fairly, but that doesn't lead to a conclusion that you don't have any system of evaluation or any process; right, because you need to pick - our organization publishes for open-heart surgery a document that lists the raw volume numbers for open-heart surgery. We would love to substitute that with a system of severity-adjusted outcome measures for open-heart surgery. Have never been able to do that because there's never been an agreement within the professions applied what the heck that is. They all disagree on what is the right - everyone wants to severely adjust their problems greatly and less other people problems. So I think this is something that needs to be dealt with great caution and concern. It's - the Commission put these volume things in by physician a few years ago, and the answer is since the department did not fulfill its proper responsibility according to the (inaudible) monitoring them, not that they, we're just going to wipe out the requirements. I think these are important things, important things to have and not be in a position, as Dr. Ajluni pointed out that it just happens that somebody said I only do ten a year. There's a lot of people who think they wouldn't want to go to someone that does ten a year. There are other outstanding problems. There's no question that you would

rather have a multi-year analysis, you would like to not have - you'd like to have severity and adjusted and everything else, but there's a lot of concern about this, and I strongly urge the Commission to take deliberative action. Possibly this is one instance where you do want to use an advisory committee to consider how you balance this out. A consumer's interest in having quality information by doctors and by hospital, purchasers interested in doing that, and so forth. If you don't, then what you're going to end up with is people Leapfrog, of which our members are leaders, will decide well, they'll monitor this, or do you want to have a system which is more collaborative? Thank you.

MS. TURNER-BAILEY: Any questions?

MR. GOLDMAN: Yes.

MS. TURNER-BAILEY: Commissioner Goldman.

MR. GOLDMAN: I have a motion. Motion would be to thank Dr. Bates for his report. We accept the report and forward it to either the department for their review, analysis and (inaudible) -

MS. TURNER-BAILEY: Well, since we're in the - we put this in the discussion - within the discussion of the work plan because it - there was a possibility that we might think about doing that, and so there's a motion on the table. I haven't heard a -

MR. BREON: Support.

MS. TURNER-BAILEY: Okay. Support by Commissioner Breon. I'm not real sure if we needed an action on this, but any discussion?

DR. SANDLER: Yes.

MS. TURNER-BAILEY: Yes, Dr. Sandler.

DR. SANDLER: I'm a little confused as to how the discussion is taking place here. My understanding is that Leapfrog is what the leading edge for quality is. They've embraced this idea, and they seem to indicate the volume standards aren't of much value.

MS. TURNER-BAILEY: I don't think -

DR. SANDLER: I also believe -

MS. TURNER-BAILEY: - I agree with that.

DR. SANDLER: - the volume standards are of very little value. If anything, Dr. Bates' proposal, you'd more than likely have accountability, but perhaps not accountability at the individual level is what the concern could be. The other thing that I'm also confused about, the first part of Larry's testimony. Perhaps I didn't understand the last cardiac cath proposal. In the situation - and you can probably help me with this, that Dr. Bates is proposing a cath lab at Foote Hospital in Jackson which is now going to be able to do cardiac caths on post MI patients - not cardiac cath - angioplasties on MI patients, that's going to be reported under your proposal; correct, the lab will be reported?

DR. BATES: With all due respect, I think Larry's completely confused this issue. I was here before in front of the Commission talking about Section 5 and Section 12 which have been revised to allow very stringent monitoring and reporting for a couple hospitals in the state that want to do emergency angioplasty on patients with heart attacks. This has absolutely nothing to do with that. This has nothing to do with Section 5 or Section 12. None of those agreements that were negotiated over 18 months are going to be challenged by this. This is simply individual reporting by physician, not by laboratory, as you mentioned. It has nothing to do with MI. It's individual reporting and procedure volumes.

DR. SANDLER: Correct. So the same procedure volumes would be reported regardless.

DR. BATES: Right. And, in fact, as part of that new law in Section 5, patients getting angioplasty at these hospitals that don't have on-site surgery are reporting their data to the NCDR. Those data will be reported to the state and to a group supervising the program that will help the state interpret these data. That is the most regulated area of cardiology right now in this state, but that, again, has nothing to do with this concept which is simply quality improvement. If I go to the Ford dealership, I don't care how many cars the Ford guy sold. I want to make sure that my car is high quality. And the concept of volume, even though that's been embraced in the past, and Larry's groups done a lot of work on that with bypass graft surgery, in cardiology that concept's ten years old. We've gone beyond that to reporting outcomes, and it's a much more reasonable way to evaluate quality.

DR. SANDLER: It would seem to me what Dr. Bates is proposing there'd be more stringent criteria than the previous criteria and would be (inaudible) -

DR. BATES: It's far more demanding and it puts the burden back on the free market where the hospitals actually would be competing against themselves to improve quality. You're going to have the top ten hospitals being able to be compared to the worst ten hospitals, and I'll bet you that changes practice in the ten worst hospitals.

MS. TURNER-BAILEY: And I think there is a motion on the table to get work to - forward it to the department for information to put this on the work plan. I think there's going to be - I know I for one am not prepared to make a decision on this issue today based on the discussion that we've had, but certainly there is a motion on the table to put this issue on the work plan. It has been supported. Is there any discussion with regards to that particular motion? Hearing none, all in favor signify by raising your hand. All opposed? Motion passed - motion carried. I think we had one that abstained - one abstention, but I don't know that that's a count that I needed to make.

MR. STYKA: Is your arm tired?

UNIDENTIFIED SPEAKER: I don't think you can -

DR. SANDLER: I'll tactfully restrain myself. I don't believe this is -

MR. MAITLAND: You said restrain.

DR. SANDLER: - a wise use of the department's time, frankly.

MS. TURNER-BAILEY: Well, I think - you know, I think we can go from one extreme - this is a personal comment, a commissioner trying to be able - we can go from one extreme to the other. We can go to, you know, sort of this question of taking too long to do things, but we can also go to other extreme which is, you know, shooting from the hip, which I think is a -

MR. SANDLER: And I was going to keep my mouth shut.

MS. TURNER-BAILEY: With regard to the work plan, Brenda, can you walk us through where we are and we may want to make some changes to them. We've already agreed to one, but can you just walk us through that, please?

MS. ROGERS: Okay. In your binder you should have a work plan. It should have said draft on it.

MS. TURNER-BAILEY: You need a microphone.

MS. ROGERS: Again, this is Brenda. In your binder you should have a copy of a draft work plan on it that shows some strike-outs; okay? It should have said draft on it, and I apologize for that not being on there, but that's the work plan I'm going to work with. I think that everybody should have that. The first thing on there, the cardiac cath and open-heart surgery Ad Hoc Committee, their work was finalized, the standards were adopted, so the suggestion would be to remove that; however, what you just voted on, cardiac cath, would remain on the agenda, but the open-heart piece would be removed. CT, you took proposed action, so we will schedule a public hearing for that. And then from there, we will move that forward and take it for a final action at the

December meeting. Hospital beds, we've actually - you've agreed to hold a special commission meeting to address this issue, so hospital beds will remain on the work plan.

MRT remains on the work plan in hope that we will have some draft language for the December commission meeting. Surgical services remains on the work plan, and, again, working on that draft language for possibly the December commission meeting. Lithotripsy remains on the work plan for proposed language for the - either the upcoming special commission meeting or the December commission meeting depending on what the commission decides. New Medical - excuse me. New Medical Technology - it's late in the day here - remains on the work plan. CON annual report is removed. That was presented to you at the last commission meeting. The Hospital Beds, as far as 2209 sub (9), that issue will come off the work plan. action, we will leave that on the work plan since there are still pending issues with that. The other thing to take note is since the Commission took proposed action to add the Medicaid and other technical changes to all of the other various standards, we will be adding all of those standards to your work plan to show that. Okay. That's what I have at this point. So your next work plan probably will be a two-pager.

MS. TURNER-BAILEY: Okay. Are there any questions or comments on the work plan?

MR. MAITLAND: Just to save paper, can't you just put all of those under one grouping, you know, just one line.

MS. ROGERS: I'll play with it. We'll see.

MR. HART: Renee, we do have some dates available for the special meeting if you want to discuss that now because I know some commissioners do have to leave.

MS. TURNER-BAILEY: Okay. We can do that. I need to just wrap up quickly on the work plan if there is a motion to adopt the work plan. Yes, Amy. Sorry.

MS. BARKHOLZ: Amy Barkholz, MHA, we had folks come and testify to the proposed language on MRI. Is it possible to put it on the work plan to continue to work with you all and work towards drafting language that you can take a look at? That was our requested action from our comments today.

MS. TURNER-BAILEY: Is there a motion?

DR. SANDLER: I would so move. Second.

MS. TURNER-BAILEY: You're moving to add MRI to the work plan?

DR. SANDLER: Right.

MS. TURNER-BAILEY: It's been moved and supported that we add MRI to the work plan. Any discussion? All those in favor, please raise your hand? Opposed? We still have six here; all right?

MR. SMANT: I move that we adopt the work plan as amended.

MS. TURNER-BAILEY: It's been moved that we adopt the work plan as amended. Is there a support?

MR. GOLDMAN: Support.

MS. TURNER-BAILEY: Moved by Commissioner Smant. Supported by Commissioner Goldman that we adopt the work plan as amended. Any discussion? All those in favor raise your hands? Opposed? Motion carries. Okay. We have the future meeting dates that are listed in here, agenda. The next regularly scheduled meeting is December 9, and we have some possible dates for our special meeting.

MS. ROGERS: Again, this is Brenda. I just wanted to make a note. There's just a typographical error. June 15th, 2003 should be 2004 for your information.

MS. TURNER-BAILEY: Okay. What are the dates, Brenda?

MR. HORVATH: 9/23, 9/24, 9/30, 10/1, 10/2, so that's Tuesday 9/23; Wednesday, 9/24; Tuesday 9/30; Wednesday, October 1st; and Thursday, October 2nd. We can do it two ways, either set a date here or -

MS. TURNER-BAILEY: Well, can we get everybody to just send an E-mail quickly with their availability because I think we have - we have some - several dates that are available. We could probably finalize that, if not today, at least tomorrow.

UNIDENTIFIED SPEAKER: Excuse me commissioners. Could you give us the best three dates?

MS. TURNER-BAILEY: The best three dates.

UNIDENTIFIED SPEAKER: - and then we will try to get a quorum on -

MS. TURNER-BAILEY: And we'll try to get a quorum and then we have a couple of commissioners that already have left.

MS. HAGENOW: Did you say Saturday, the 25th as well as the 23rd, and 24th?

MR. SANDLER: No.

MR. MAITLAND: I missed -

MS. HAGENOW: The 23rd and 24th?

MR. STYKA: Let's go through it one more time. We have - Tuesday the 24th is available. Anyone else not able to make it on the 24? What we can do is we will E-mail these dates out, if you can give us your best three dates and then we will shoot for a quorum on the dates. We'll get Renee to indicate how many days are available and which ones have a quorum and -

DR. SANDLER: Does anybody agree with the 24th? I never heard anyone disagree with the 23rd.

MS. TURNER-BAILEY: Public comment. I have several cards here. Barbara Jackson.

MS. JACKSON: I'm still Barbara Jackson from Economic Alliance. From the peanut gallery based on the new directive about no copies to be distributed besides draft language in the agenda, it makes it really difficult for those of out in the audience to kind of follow along and be able to be a part of the process. Perhaps the departmental things could be put on the web site, that could help, in terms of the work plan and some of the other issues. And people were bringing copies of things, maybe they can bring extras. I know when we do, we try to do, but it would really be helpful. It would make it, I think, a more deliberative process for everybody to be included. And as we agree with Mr. Styka, when he commented that, you know, it makes it part of the - the friendlier part of the open meeting act to be able to have everybody be literally on the same page.

MS. TURNER-BAILEY: Okay.

MS. JACKSON: Thank you very much.

MS. TURNER-BAILEY: Thank you. I think that's an excellent suggestion, so if you bring copies that you want to pass out, it would be - if your company's making copies these days, please bring copies for everyone and then we'll - whatever we can get on the website, we will get on the website and try to get those things on as far in advance as possible.

MR. BREON: The executive order was only up until September to Brenda and open unless there is another to be continued.

MS. TURNER-BAILEY: Well, right now it's been September 30th, but, you know, it's possible we may have a meeting - another meeting before then. We are trying to post as much as possible on the website.

MS. TURNER-BAILEY: Okay. Thanks.

MR. MAITLAND: Maybe they could just bring blank paper.

MR. HORWITZ: Another.

MS. TURNER-BAILEY: Yeah.

MR. HORWITZ: At the same time I did want to cardiac cath. Dr. Bates was explaining that this was not an effort to overturn the primary angioplasty, section five. We didn't know that. There's no way, given the fact there's no advanced information or knowledge of what is coming up and that he had copies to pass out, but he didn't know he should. Two, the concern we do have, I appreciate the Commission asking for - not taking - I'm not taking action to adopt this right away is that there is a great interest among many people, purchasers and consumer groups to have information comparing doctor by doctor. That is a very important part of your health care choice process. I'll be glad to contact the Leapfrog people, General Motors is the bullfrog, is the title at.

MS. TURNER-BAILEY: Actually, just, so you know, Dr. Vince Kerr is the bullfrog right now.

MR. HORWITZ: Vince is the current bullfrog.

MS. TURNER-BAILEY: Yes.

MR. HORWITZ: Okay. That's there term of endearment for their head person. Okay. But I know that Dr. Kerr and the GM people and others are otherwise engaged for the next ten days so give them a chance to finish their otherwise scheduled activity and find out from them what their current thinking is, but we can talk with the staff, and be able to - look forward to working with Eric and others to see if we can resolve some common viewpoint as we successfully did on the CT/PET combo. Thank you.

MS. TURNER-BAILEY: Okay. Pat Lamberti.

MS. LAMBERTI: It wasn't quite clear where my comments or observations would fit in so I'll take that opportunity now, however, I will keep them brief especially since I now know I stand between you and adjournment.

My name is Patrick Lamerti and I'm president and CEO of Pontiac Osteopathic Hospital. POH, like many hospitals in Michigan, has been closely following the changes and the proposed changes of the existing CON methodology for the distribution of hospital beds. We, too, are quite interested in reaching conclusion to this issue. With that in mind, we are requesting that the CON Commission convene a work group to further study the distribution of hospital beds in Michigan. We believe that additional changes to these standards would benefit the hospital providers, patients and payers to this state. We also believe that a work group is actually required for the CON commission to fulfill the mandates of Public Act 619. In particular section 22215, sub 1, sub 0 of the Public Health Code, as amended by Public Act 619, requires the CON to make further study of the CON Standards for Hospital Beds within six months after appointment and confirmation of the six additional CON Commission members. This section clearly requires affirmative action by the Commission to develop, approve and revise CON standards governing each of the three following areas: The increase of licensed hospital beds, the physical relocation of hospital beds from one licensed site to another geographic location, and the replacement of licensed hospital beds from one site to another. We believe the CON Commission meeting is obligated under Section 22215, sub 1, sub 0, to address the physical relocation of hospital beds as evidenced by the proposed CON standards on today's agenda; however, we do not see that the Commission has taken any action yet to meet its statutory obligation to address, one, the increase of licensed hospital beds, two, the replacement of hospital beds as required by the act. We also do not read Public Act 619 as giving the CON Commission the discretion to develop, approve or revise CON standards to address the potential increase of hospital beds or the replacement of hospital beds. The statute clearly states that the commission shall do these things listed under the section. Thus we believe that further study of hospital beds is mandatory for the Commission to comply with Public Act 619. POH would welcome the opportunity to sit in and participate in the work group. I thank you. Any questions? Thank you.

MS. TURNER-BAILEY: Tom Pietruk: Pass.

MS. TURNER-BAILEY: Okay. That's the last card then. Dr. Sandler.

DR. SANDLER: I have one question. Did we settle where lithotripsy is going to be placed on the agenda?

MS. TURNER-BAILEY: That's a good question. We did not settle that, but I think we need to -

DR. SANDLER: Which one of those - can I make a suggestion?

MS. TURNER-BAILEY: I'm thinking December but...

MR. STYKA: I think that's what Goldman said he would prefer. He's not here but -

MR. BREON: My assumption was it was going to be in December.

MS. TURNER-BAILEY: I'll accept a motion for adjournment.

MS. HAGENOW: So moved.

DR. SANDLER: Accepted.

MS. TURNER-BAILEY: To move and support that we adjourn. We're adjourned. (End of the proceedings.)